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George Bugbee, Executive Director

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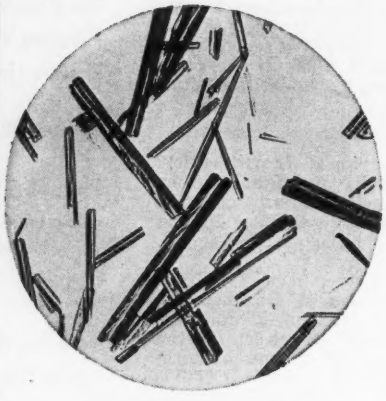

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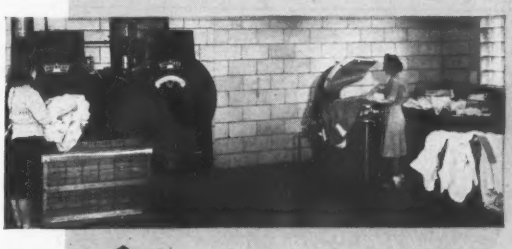

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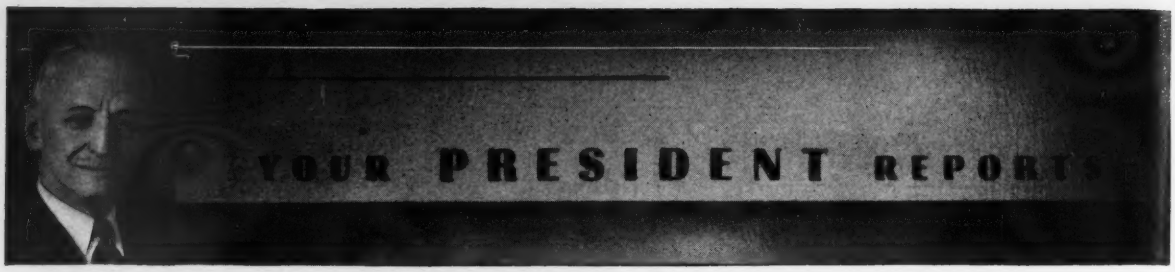

I AM APPRECIATIVE indeed of the rich opportunity which this column will afford me for comment during the next 11 months. I write this with a mindfulness of the responsibility which my assumption of the presidency of this great Association brings. I yield to no one in my regard for the honor it imposes upon the individual filling this office, and one would be foolish indeed to approach this task with anything but a realization of the frailties which humans possess. Honest mistakes, errors in judgment may easily bring about disappointments to good friends who have played a generous part in making this great honor possible. One can but do his best and pray that he may be equal to the task.

LOOKING back upon almost a quarter of a century of attendance at the annual meetings of our Association, I have seen these gatherings grow from a registration of hundreds to the 7,936 at the most recent one in Atlantic City, the very largest in the convention history of the American Hospital Association. I have seen the exhibit space increased to a capacity taxing the largest auditorium in America. I have seen the program develop from one of modest effort to present the problems of hospitals to one broadened to the inclusion of momentous world affairs in their effect upon the care of the sick and hospital management.

AT THIS time I deem it fitting to pay tribute, as I did in my acceptance of the presidency of the Association, to the 51 earlier presidents of the Association, who have played so historic a part in the development of our Association, in a period of a little over a half century, from a very humble beginning to its present imposing size. As I stressed on this historic occasion in my personal life, the whole subject of hospital management and hospital service is so close to us in our everyday lives that we may readily fail to appreciate the parts played by these men, the sacrifices they have made, and the contributions which were theirs to the growth of the American Hospital Association.

We are prone, too, to fail to appreciate in its fullest sense the work of the executive group in the offices of the Association, so ably led during the more recent years by the indefatigable, tireless and dynamic George Bugbee. I am sure we all share in an appreciation of the values of this leadership as well as the earnest devotion of all at headquarters in making our continuous and healthy growth possible. The work of John Storm and his associates on HOSPITALS makes available for us every month, in fine readable form, information of importance to the hospital field.

I KNOW that I will be forgiven for availing myself of a little space in this column to do more than to pay tribute to John Hatfield, but

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also to thank him for his kind words of introduction. These I shall never forget, and for them I shall always be grateful. Opportunities which I have had over a period of almost a decade, both to serve as a member of the Board of Trustees and afterwards to work closely with them in my capacity as president-elect, cannot help but make me grateful for the privilege I have had to work shoulder to shoulder with the officers of the Association for the common good. They come and they go. New replace the old. The synchronization of necessary effort, however, in the transfer of the mantle of responsibility from the shoulders of retired officers and trustees to those of the new incumbents, the picking up of these functions and responsibilities with very little lost motion, is but additional evidence of the smoothness of the performance of those who guide us as well as carry on the daily manifold responsibilities.

To anyone who may feel that there is overemphasis in this my first column, I beg indulgence because of gratitude on my part created by the opportunities for observation, lacking to others, who have not been so close to the operating and administrative picture.

THERE is an old saying that "we take out of anything only as much as we put into it." Surely those engaged in the varied phases of hospital pursuits put in a great deal. The finished product is better health for our men, women and children. While conditions for hospital personnel have improved, we have not forgotten the period of poor wages and salaries, the long hours, the many sacrifices involved in this field of operation. The end results of devoted efforts of those engaged in this field is best reflected in improved health, the lessening of the duration of illness and the hazards accompanying the same. That is "what we take out" as the result of the earnestness and application of all who toil in the vineyard of hospital service.

THIS message is in a marked degree devoted to one of appreciation to all who have played a part, in the past and today in the evolution of hospital development. Those messages that will follow in this column during my term of office as president will be in a greater sense devoted to narratives descriptive of my travels to various state and regional meetings of the members of our Association. I am very grateful and proud of the fact that I have already received many gracious invitations to participate in these meetings. As John Hatfield stressed a year ago, you would need several presidents to attend them all. I can only say that I look forward with a great deal of anticipation and much pleasure to the acceptance of as many as are humanly possible. To the fine men and women who will invite me and to whom I may be obliged to express regrets, may I say at this moment that it will be due only to my inability to be in two places at the same time and for these reasons:

There are scheduled a number of meetings of the Board of Trustees and of the Coordinating Committee, and there will be meetings of important councils which your president, as a duty and responsibility, must attend. The war, which we all hopefully pray will soon end, will entail necessary visits to Washington and to other places. The least one can do who has been honored so richly is to fulfill these obligations in the spirit of a sense of duty and with a mindfulness always of the unselfish devotion of his predecessors.

IN CLOSING, therefore, I salute with pleasure and satisfaction the membership of the American Hospital Association in this, my first presidential message, and express the hope of meeting and shaking the hands, during the year, of many individuals and greeting them with warm regards as I tour the country.

Charles F. Wilinsky, M.D., President,
American Hospital Association

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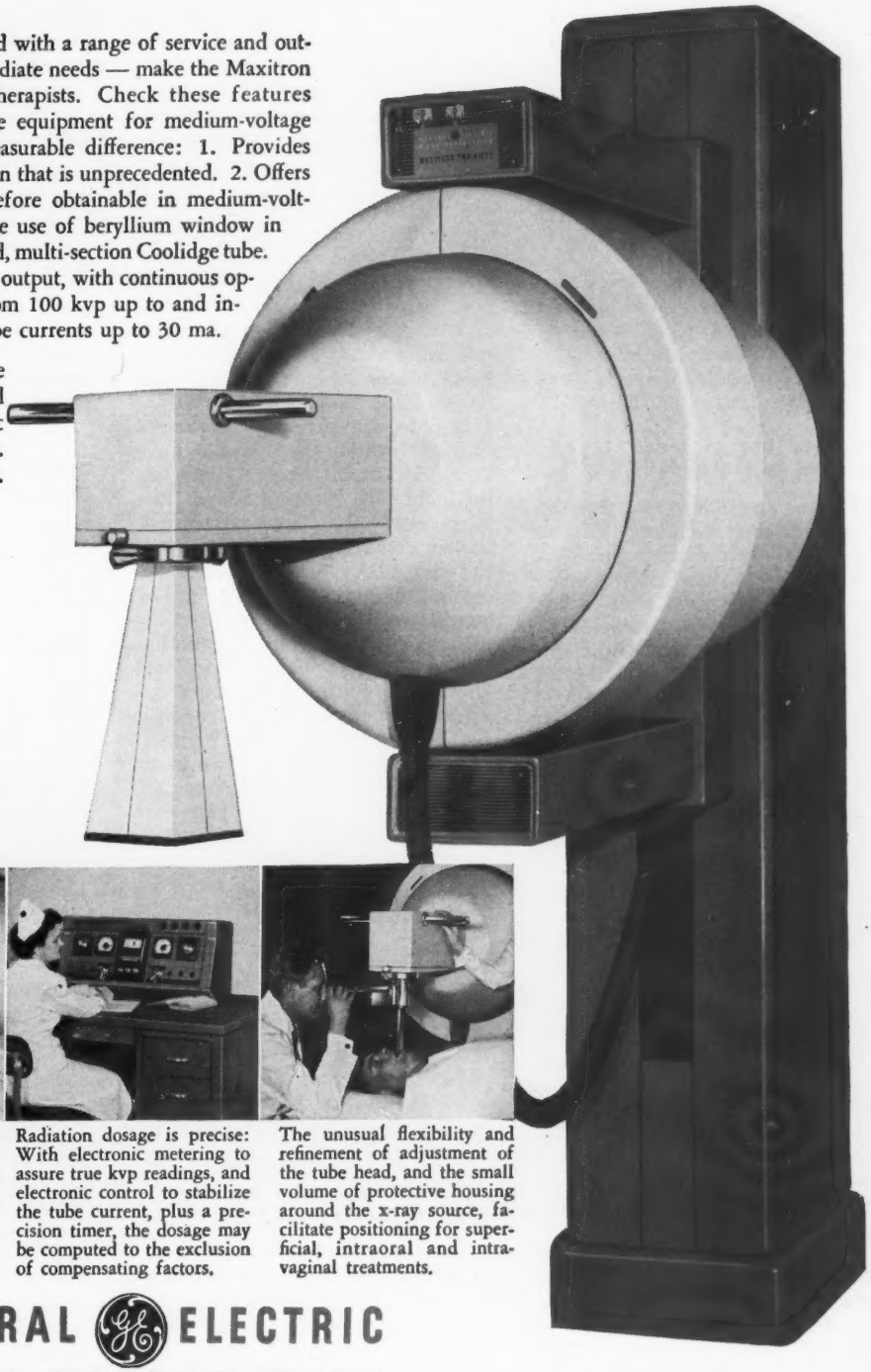

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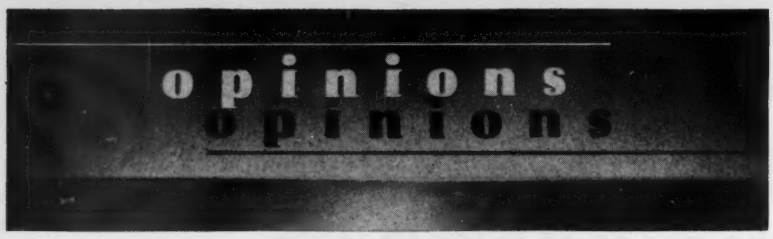

ON USE OF VOLUNTEERS DURING WARTIME

THE SHORTAGE of graduate nurses is a problem that has confronted hospitals for years. If the present war situation becomes even more serious, a shortage of other hospital personnel may be added to the administrator's "problems-to-be-solved" file. Six of these heads of hospitals and one director of volunteer service, in reply to the question—"Do you foresee any different or greater role for volunteers should another full-scale war develop?"—tell of their ideas and plans to be used in such an emergency. Many of them are based on past experiences.

Increased use of aides expected in wartime

SHOULD ANOTHER WAR develop certainly Maine General Hospital would use even more volunteers than in the last war. The expectancy for a larger number of volunteers is based on the increase in the new opportunities found for volunteers following the recent war experience.

During the last war most of our average of 550 volunteers were nurse aides. Of the 363 volunteers on my files today, none are serving in that capacity. The volunteers today, however, are working around the clock in 20 different departments and on approximately 100 different jobs.

Judging by the past, I would say that our first need, should full-scale war develop, would be to supplement the present volunteers with a large corps of nurse aides to assist the professional nurses. Of the more than 400 Red Cross nurse aides trained here during the last war, I would expect at least 100 would be available at once. Also, the Red Cross, I understand, would start new classes of nurse aides.

Next in importance I would place the men volunteer aides. This was a group of about 30 public-spirited citizens, for the most part Rotarians, who served faithfully in three departments, maintenance, housekeeping and emergency room. Two of these men are still active in the latter place, each with over 2,500 hours of service to his credit. A happy development is that these two men have been made members of the board of corporators of the hospital.

Surely, we would need an increased number of volunteers in our dietary and housekeeping departments, where the employment is least stabilized in times of emergency. During the last war, a group of students from a local junior college served very capably in these places and doubtless would be available again.

Due to the changing personnel in our hospital, there would have to be additional training and adjustment on "both sides of the fence" before an accelerated volunteer program could be expected to work most effectively. The personnel, including student nurses, would have to understand that the nurse aide is here, not to take her job away from her but to help her. Most mature volunteers are women of position in the community. They have homes of their own and are here to assist in an emergency as their gesture toward aiding the war effort. They are only too glad to return to their normal busy lives when peace comes.

To summarize, volunteer service at Maine General Hospital was born because of a war, was found much too valuable to dispense with at the conclusion of that war, and would continue its fine record at an accelerated pace in the event of another one.—MRS. PEARL P. BACHELDER, *director, volunteer service, Maine General Hospital, Portland, Me.*

Armed forces and industry will take many workers

IF HISTORY REPEATS itself, which it seems to be doing, we shall soon be faced with the siphoning off of a great many of our hospital workers. Whether we get into a "hot" war or not, we believe the stage is set for a military force of 3,000,000 men at all times. We must face the facts and set our house in order. Our hospital trustees say that we cannot compete with war industry in payment of wages. Employees, therefore, will be leaving us for war plants.

Volunteers will again be seen in our halls. During the last war the volunteers were some of our most intelligent workers. They came from our finest homes and with college educations. Men and women came from banks, law offices, and all kinds of businesses and did a fine service in the afternoons and evenings and on weekends.

We were fortunate in our hospital in having Joan Fontaine. Because she acted as a Red Cross aide and did such things as giving baths, thousands of others took their cue from her and got in and worked like Trojans.

We need them; God bless them! Our hats are ready to come off again to them.—PAUL C. ELLIOTT, *administrator, Hollywood Presbyterian Hospital, Olmsted Memorial, Los Angeles.*

Civilian training program of last war to be used

IN THE PREVIOUS WAR Manchester Memorial Hospital had a very rich experience in utilizing the services of volunteer nurses' aides. Our volunteer program did not extend to other departments at that time. In view of our present enlarged hospital program, however, I am sure that any future full-scale war would find Manchester prepared to use such volunteer services in its various other departments. In view of the seriousness of such a situation that might develop and the fact that such arrangements cannot be made overnight, we already have completed verbal agreements with the instructors and Red Cross officials who, with us, were responsible for so successfully conducting such a program for us during World War II.

Briefly, our program for nurses' aides and others would consist of having an instructor properly educate and train such people and at the same time thoroughly indoctrinate them into the hospital atmosphere. Since our present building program will soon be completed, we shall have ample space available for such instruction. Volunteer nurses' aides would be taught in their classroom the proper techniques and procedures that they would expect to find on the

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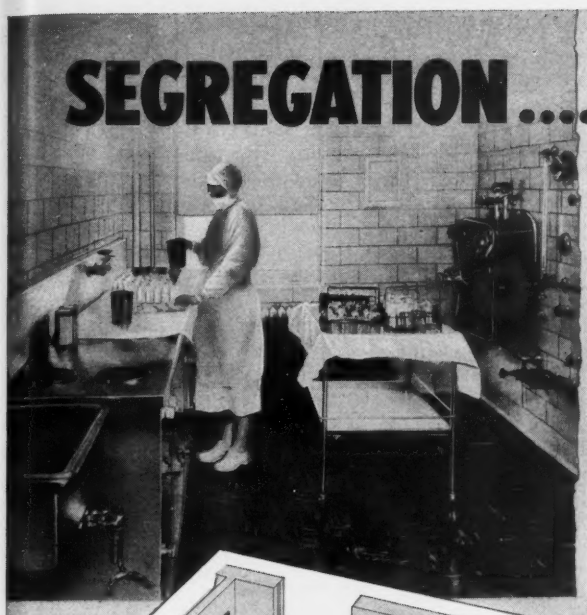

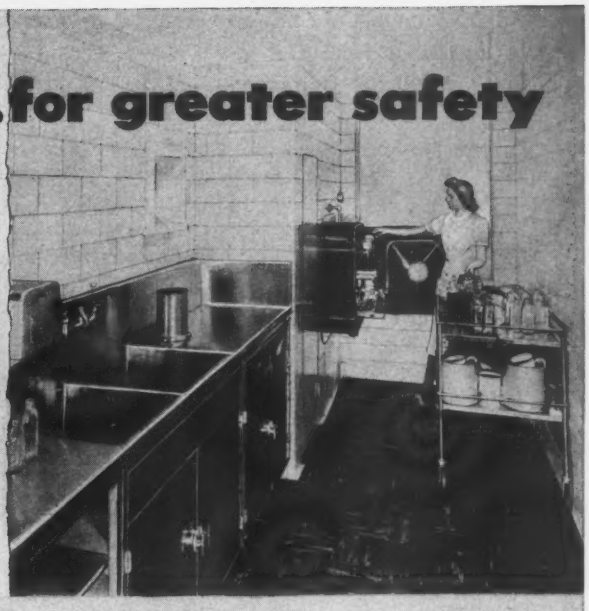

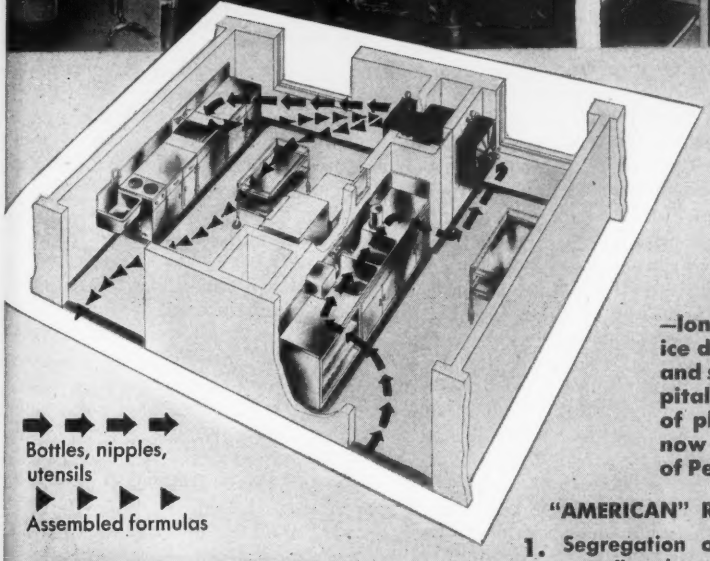

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floors while attending the patients. Any program that in itself is good and sound for nurses' aides could be applied equally as well in principle to other volunteers who might work in other service departments. We naturally presuppose that the instructor would follow up her teachings by personally supervising the work of her student volunteers on the floors to see that everything is done "according to scripture."

Judging from the many favorable comments we have had in the past from our patients, we have every reason to feel that they would continue to approve having their "fellow citizens" attend them during their hospitalization. No less grateful have been graduate nurses in our hospitals for the valuable contribution made across the country by our patriotic volunteers.

This type of work seems to be a challenge to many women who have the instinct and inner feeling to want to serve suffering humanity. I find that many of them have expressed the desire that they wished they had been nurses. Such an ambition, coupled with patriotism, becomes an unbeatable combination. The American public, when any problem has been intelligently presented to them, have always responded. Tell the people the facts and they will come up with the right answer.

With the American people using our hospitals to a greater extent than ever before, together with the fact that there has been a distinct shortage of nurses now for some 10 years, the only conclusion we can draw is that nurses' aides and other volunteers will be needed more than ever and in greater numbers.—WILLIAM P. SLOVER, *superintendent, Manchester (Conn.) Memorial Hospital.*

Volunteers will be needed more than ever before

AT THE BEGINNING of the last war there was a greater margin of labor available than at the beginning of the Korean War. This is true in the industrial field; shortages are not limited to hospitals. Many hospitals are not in so advantageous a position with reference to professional and nonprofessional personnel as they were in pre-war years. If we found volunteer assistance of inestimable value during World War II, certainly that same help will be more urgently needed in the event of a continuation of the Korean War.—MABEL W. BINNER, *administrator, Children's Memorial Hospital, Chicago.*

Former experience proves value of nonprofessionals

BECAUSE MAN AND ALL those ills and shocks that flesh is heir to are not too variable, taking care of him and his ills remains basically the same, despite advances in methods of diagnosis and treatment and improvements in the types of equipment used. It is reasonable to suppose, therefore, that should the need arise, volunteers would render essentially the same services that they performed during World War II. Having learned the value of such volunteer service, we hospital people will assign duties more confidently and be less hesitant to entrust capable volunteers with important assignments. Volunteers with past experience to their credit will themselves not only serve more intelligently and diligently but will also by precept and example become valuable teachers for the novice.

There will be less hysteria and suspicion. Our personnel, convinced that the volunteer in the hospital is not there to usurp the job of the paid worker, will be less resentful and more cooperative. The "grande dame" who rushed into the hospital, waving her jewelled fingers and avowing she'd do anything—scrub floors if necessary—will be supplanted by the volunteer who accepts her assignment with dignity and assurance, confident that she is needed and has been given the job for which she is best suited.

On both sides of the ledger, the trial and error period is over. We in the hospital field have a clearer conception of what can and should be assigned to the volunteers, and those volunteers know what is expected of them. The pattern has been set, and, if our experience during the 1940's is any criterion, they will do their job well.—FLORENCE KING, *administrator, Jewish Hospital, St. Louis.*

Additional jobs could be handled by volunteers

SHOULD ANOTHER full-scale war develop, we would see both a different and a greater role for volunteers in our hospitals. Since the last war we have seen a greatly increased number of beds in operation, both voluntary and veterans beds. At the same time our working force has failed to increase commensurate with the increased bed capacity. In the event of a full-scale war, our defense industries would again tax our working population, which to my mind would greatly increase this shortage of trained personnel and at the same time create a shortage of untrained subsidiary workers.

By and large, our experience with volunteers such as Red Cross aides and Gray Ladies was very satisfactory. With that experience behind us and the mistakes we learned from that, we should, and, I believe, shall, have to build and utilize a greater supply of such volunteers. Most of our experience with them showed their great value to the hospitals in relieving our regular, trained workers of much of the load.

We could teach them more duties and even greater responsibilities in several fields that were not fully explored in the last war. In times of war, why couldn't we train them as receptionists at information desks, as guides in the hospital, and—this is not too radical a thought—even as relief on switchboards, which would be terribly overburdened. They could be utilized more in our nursing departments in duties that do not call for technical skill.

Utilization of volunteers in such an event would certainly warrant a director of volunteer services. In all fairness to these volunteers, to make them feel at home, management should provide this on a 24-hour basis. A closer liaison should be established between these volunteers and the fulltime personnel of the hospital. In too many instances during the last war we did not take enough time for this, even though at the same time we were appreciative of the assistance that they gave us.—JOHN G. DUDLEY, *administrator, Memorial Hospital, Houston, Tex.*

Men also can give time to hospital during war

SHOULD ANOTHER full-scale war develop, it is my belief that the volunteer will play a much greater role in the hospital than ever before.

With the increasing number of beds being provided and a corresponding increase in the shortage of nurses and other trained hospital personnel, the volunteer must, of necessity, be used to max-

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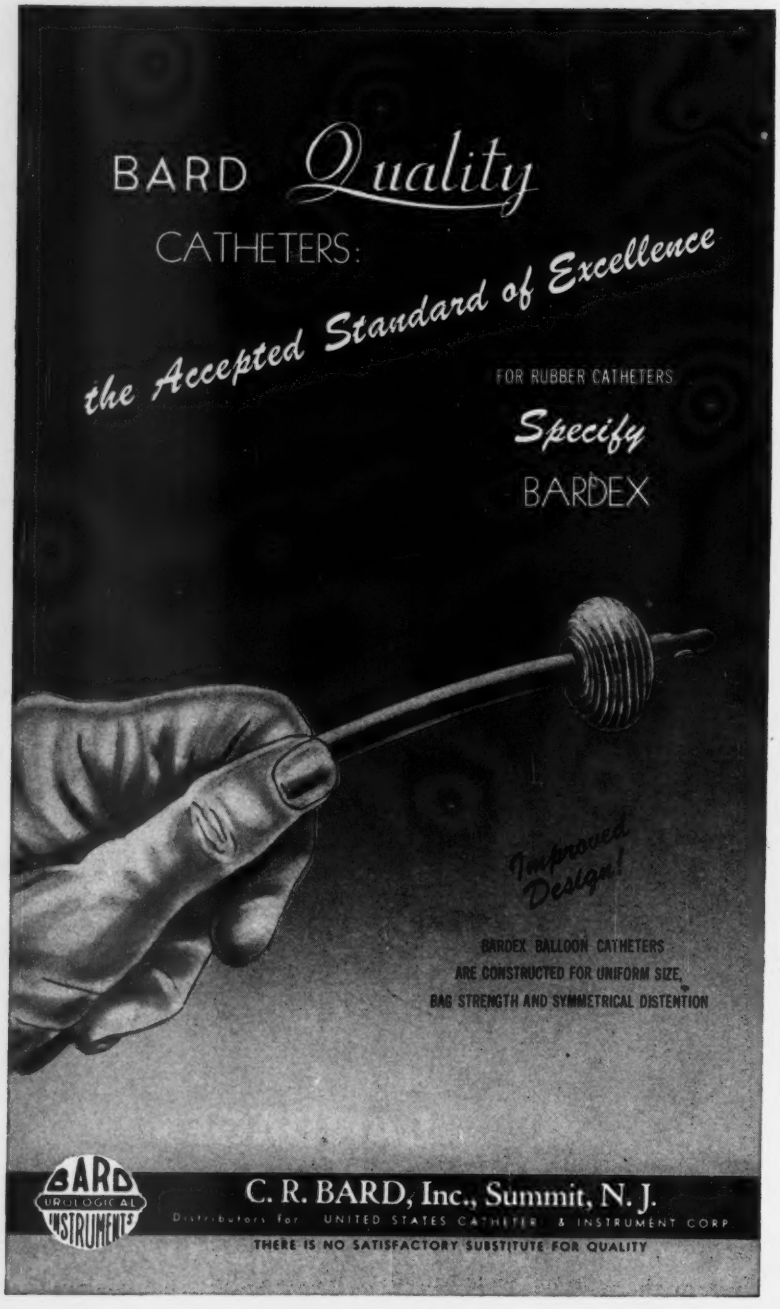
imum advantage. Unemployment in most parts of the country is near a record low, and many who might turn to hospitals for employment seek better-paying jobs in industry.

We are all familiar with the wonderful work done by the Red Cross nurse aides during World War II and the many who have continued to serve in that capacity since that time. The Gray Ladies with their many projects are of great help to the hospital.

Volunteers can be organized for many projects besides those of bandage rolling and gauze cutting. Gift shops and snack bars can be manned by volunteers, as can a library service for patients, a hostess service, messenger service, baby sitting in the hospital lounge during visiting hours, clerical help in addressing envelopes, mailing statements and home sewing groups.

When we think of volunteers, most of us have the women in mind, but let us not forget the men. There are many things around the hospital that can be done by a group of men sincerely interested in its welfare, such as maintenance of the grounds, tree trimming, shrubbery planting, flower beds to be worked, painting of both exterior and interior, floor maintenance and wall washing.

In fact, there are relatively few nonprofessional jobs that cannot be done with volunteer help if the project is properly organized and supervised. The most important phases in the use of volunteers are the proper indoctrination, training and supervision of such personnel. The use of volunteer personnel is a means of continuing our voluntary system of hospital care.—HUBERT W. HUGHES, *administrator, General Rose Memorial Hospital, Denver.*



California Unionization

(In the June issue of HOSPITALS, John H. Gorby, administrator of La Mesa (Calif.) Community Hospital, described labor union activities with respect to hospitals on the Pacific Coast. This article, "Attempts at Unionization in Southern California," prompted the following letter to the editors of HOSPITALS.)

John H. Gorby, administrator of La Mesa Community Hospital, La Mesa, California, makes it appear in an article in your June issue entitled "Attempts at Unionization in Southern California," that nurses employed at Redlands, California, Community Hospital are subject to the orders of the Building Service Employees, A.F. of L.

He stated in the article:

"The union was working hard also. Its prestige had suffered. It was recuperating and replenishing its finances. At 7 a.m. Monday, February 6, 1950, the entire staff of nurses at Redland Community Hospital resigned *en masse.* The employees stated it was not a strike but a protest with a contract as the basic demand. Administrator E. L. Jury was successful in persuading the staff to return to work until the results of an area-wide personnel survey were in. This was completed March 20 and indicated an over-all rise in the wage structure of hospitals in the Southern California area. Workers at Redlands immediately were granted a salary adjustment as had been promised by the board prior

(Continued on page 152)

ADVANCE *in antibiotic therapy*

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Crystalline procaine penicillin-G..... 300,000 units

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Dihydrostreptomycin (as the sulfate) ..... 1.0 Gm.

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MEDICAMENTA VERA

SERVICE FROM HEADQUARTERS

Military status of doctors

We are disturbed about the way interns and residents are being called for the armed services and are wondering what is being done to protect the interests of communities and hospitals.

UP TO THIS TIME the procurement of medical officers, dentists and nurses has been spotty and based on anticipating immediate needs accentuated by the Korean emergency. The military services appear to be fully cognizant of the desirability and need for protecting community interests, and our feeling is that this protection will be afforded to the degree that circumstances will permit. The National Security Resources Board has been asked by the secretary of defense and the selective service to formulate recommendations for the procurement of the personnel. Recommendations to the secretary of defense have already gone forward, and when this communication was sent, the need for protecting community interests was emphasized. The Rusk committee is functioning to advise the authorities in connection with the civilian defense, and this same committee has now been designated as the advisory group to the director of Selective Service.

Vulnerable: The organized reserves and the ASTP and V-12 groups will be vulnerable beyond any question. It had been hoped that the new draft legislation and the policy promulgated by the military forces would insure a sufficient number of volunteers to take care of immediate needs, but this has not been the case. As a result the army has had to call up a number of World War II veterans to insure proper staffing in military hospitals, but an effort has been made to confine the number to a minimum. Early last month, in view of its shortage, the army asked that the navy furnish several hundred physicians from its V-12 group. This has been done to a limited extent. The army still has many vacancies, and additional hospitals have been opened. The navy and the air force are in a much better position and probably will not recall any great number of reserves prior to the activation of the draft law.

Conversations with planning officials indicate the probability that medical students in good standing and interns who have not completed the required internship will be allowed to continue on to complete at least one year of internship. On the other hand, there has been no indication that residents would be allowed to complete residencies already begun. This is not a definite determination; it is merely an indication of the probability.

Deferments: Professional personnel apparently will be deferred only on the basis of personal hardship and the needs of the community. Reserves in the ASTP and V-12 classifications will have no chance of deferment where their services are definitely needed, except on the basis of community needs. Request for deferment should be sent through the command of corps areas and commandants of naval districts, depending on the arm of the military service involved. The local boards set up in various communities throughout the country will correlate the arguments for deferment, and where indicated all the papers will be forwarded to Washington, where a personnel board will render a final decision. Assignment and procurement boards in the local communities will assume this function in connection with the draft.

Possible protection: Principles and policies referrable to induction will probably be established by the Rusk committee. This committee has no authority but may make recommendations as a guide to the authorities. Early last month representation was made to the National Security Resources Board indicating the necessity for the establishment of a policy that would assure the retention of adequate hospital staffs. This is to insure the efficient functioning of the institution on the basis of its needs as indicated by the average patient load or on some other standard that may be applied on an over-all basis. There is no definite assurance that such a policy will be developed, but all the authorities contacted have recognized the need for such a policy in the interests of the welfare of the individual patient in communities.

All physicians accepting commissions in the reserves or the regular forces will be in a position to receive additional remuneration of $100 a month. Our understanding is that this policy will hold also with relation to those individuals who are called through the draft but who accept commissions prior to the actual induction in the service. Persons who are drafted will not receive the $100 monthly bonus. —DR. DALLAS G. SUTTON.

Accounts receivable

What is the recognized percentage of accounts receivable to patient income?

It is difficult to give a categorical answer to this question as there are too many factors that would influence the ratio of accounts receivable to revenues at any given time. Such factors include whether or not your hospital has a deposit on admission policy and how extensive and vigorously followed such policy is, how quickly you attempt to effect collections on your accounts, and how soon you close out what appear to be bad accounts.

If a large percentage of your accounts receivable represents funds due from your Blue Cross plan, then the frequency of payments to the hospital by the plan certainly would affect the amount of your outstanding receivables.

Despite all the foregoing qualifications, it is contended by several top-flight hospital administrators and accountants that a reasonable balance of accounts receivable at any given time would be in the neighborhood of one month's earnings of the hospital and not greater than two months' earnings. Personally, I believe that a balance equivalent to one month's earnings is a little higher than it should be.

If it is the ratio of bad debt losses to revenues, rather than the percentage of open accounts to revenues, in which you are interested, you might refer to my comments on page 28, HOSPITALS for August.—WILLIAM H. MARKEY JR.

Staffing competition

With preparations being made by the Veterans Administration for the opening of a hospital in our area, we are being faced with staffing problems. Salaries paid by the Veterans Administration exceed those paid by civilian hospitals. Can you give us any background on this situation

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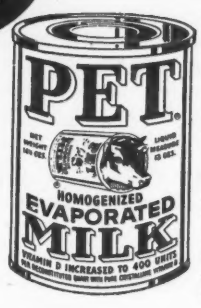

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and tell us if there is anything that we can do to remedy it?

The legislation establishing high salaries in federal hospitals has had serious effects as far as we have been able to determine. Hearings on the bill introduced to increase salaries were held by the appropriate committee, but no opportunity was afforded for those outside of government to testify. We have been informed that the Veterans Administration authorities requested this increase in pay so that it might be in a position to compete for nurses and other professional personnel with the military forces, which were paying on the basis of commission salaries.

The American Hospital Association, in its 1947 report on federal hospital planning, pointed to the fact that "on an hourly basis, the federal salary was approximately 50 per cent in excess of the salary paid in nonfederal hospitals." At the same time attention was directed to the fact that since professional personnel to be employed in veterans' hospitals were of necessity drawn from community hospitals, it was becoming increasingly difficult to staff and maintain voluntary hospitals. Copies of this report were sent to all members of Congress at the time. Since then, as Association representatives have appeared before the Hoover Commission and the various committees of Congress, this point has been stressed. The attention of Congress has been repeatedly drawn to the fact that the unlimited expansion of the veterans' system would eventually adversely affect the maintenance of hospitals that are providing care for the total population.

The situation that you are experiencing has been foreseen by our Veterans Relations Committee and the Council on Government Relations and has been set forth in resolutions of the House of Delegates at various times over the past several years.

Dr. Dallas G. Sutton, of the Association's Washington Service Bureau, obtained from the Veterans Administration a list of critical positions required in staffing Veterans Administration hospitals of 200 and 500 beds and the size and approximate opening dates of the various hospitals. These lists show the salary ranges, which are based on a 5-day, 40-hour week. (See pages 132 and 134 of the September issue of HOSPITALS.)—ALBERT V. WHITEHALL.

Funds for chest x-rays

When opening our new hospital we would like to establish routine chest x-rays on all patients. Is there any manner in which we may obtain some financial assistance, either federal, state, or local?

The situation varies in each state. The National Tuberculosis Association, however, has endorsed support by local chapters for such a program. You might discuss it with the chapter in your community. It may be that there is seal sale money that could be utilized. In principle, subject to local decision, such a procedure has been endorsed.

Also, in some instances the state health department has funds available for assistance. I suggest that you write that department of your state, requesting information about any sources of such funds.—GEORGE BUGBEE.

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The square hospital means economy

With patient rooms around the outside and service facilities in a center core, Euclid-Glenville Hospital also will save personnel.

JAY W. COLLINS

IT IS GENERALLY AGREED that a square house is the least expensive to construct and that it provides a maximum utilization of space. It became apparent in 1948 that we were going to have a substantial problem financing the construction of our new 200-bed Euclid-Glenville Hospital. We therefore determined to investigate fully whether or not a square hospital would be economical to build and operate, as suggested by Dr. Fred G. Carter in the November 1947 issue of HOSPITALS.*

As we developed the details of this building, we became immensely enthusiastic about the economy and efficiency of it. Not only is it going to cost far less to build than would more traditional designs, but it will permit maximum economy of personnel while enhancing patient comfort and quality of service.

These may seem to be rather extensive claims, but traffic flow studies and numerous analyses by competent critics have fortified our opinion that the square plan is a logical and workable method of providing maximum service at minimum cost.

The size of the basic square was practically determined for us, as is evident by looking at the fourth floor plan, which shows best the basic floor plan. By adding together the depth of the patients' rooms and the required corridor widths and the minimum footage required for the service facilities (largely determined by the necessary depth of the elevators and stairways), we get a practically irreducible minimum size of 108 feet for the square. To make the square larger would be uneconomical, for there are no additional facilities that need to be in the center core.

Thus the most economical construction unit for this square plan is a maximum of 50 beds per floor. To add more patient rooms would necessarily increase the size of the center core. This not only would increase unduly its cost but would create a surplus of space given to service facilities in ratio to that provided for beds.

To provide the necessary adjunct facilities and service departments and to keep them in proper relation to one another, it was necessary to expand the building on the lower floors. This is easily done in the square hospital by adding relatively short wings to house these nonpatient facilities without loss of efficiency. The other alternative is to make the basic square larger on the lower floors. This latter construction plan would have two great disadvantages: First, expansion of the building would be almost impossible, and second, too many of the facilities would be jammed together in the center of this larger square, necessitating the use of more corridor space and extensive mechanical ventilation.

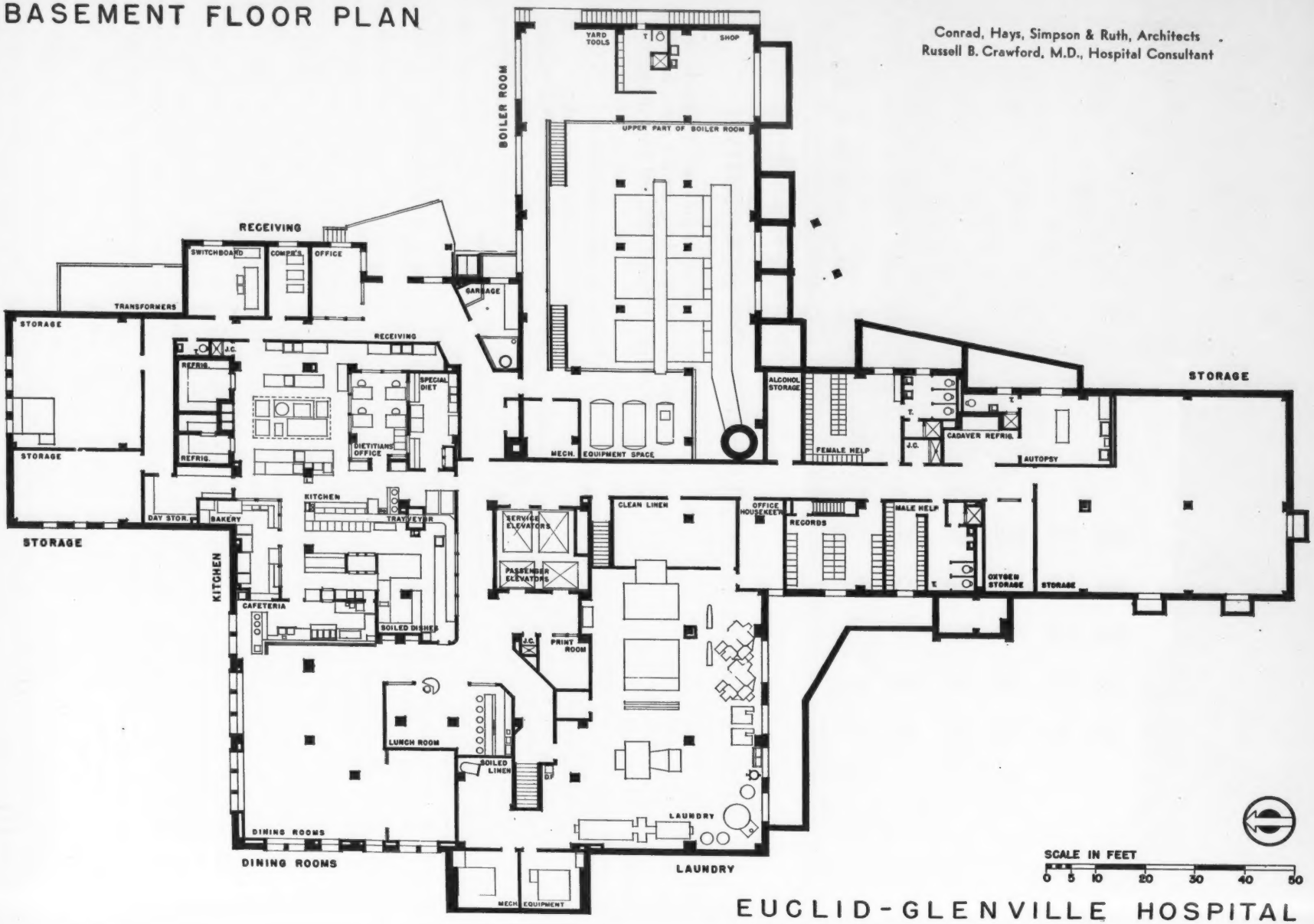
The square plan is ideal for fu-

Mr. Collins is superintendent of Glenville Hospital, Cleveland.

*"Some Reasons for Building a Square Hospital." Fred G. Carter, F.A.C.H.A., HOSPITALS, November 1947.

BASEMENT FLOOR PLAN

Conrad, Hays, Simpson & Ruth, Architects
Russell B. Crawford, M.D., Hospital Consultant

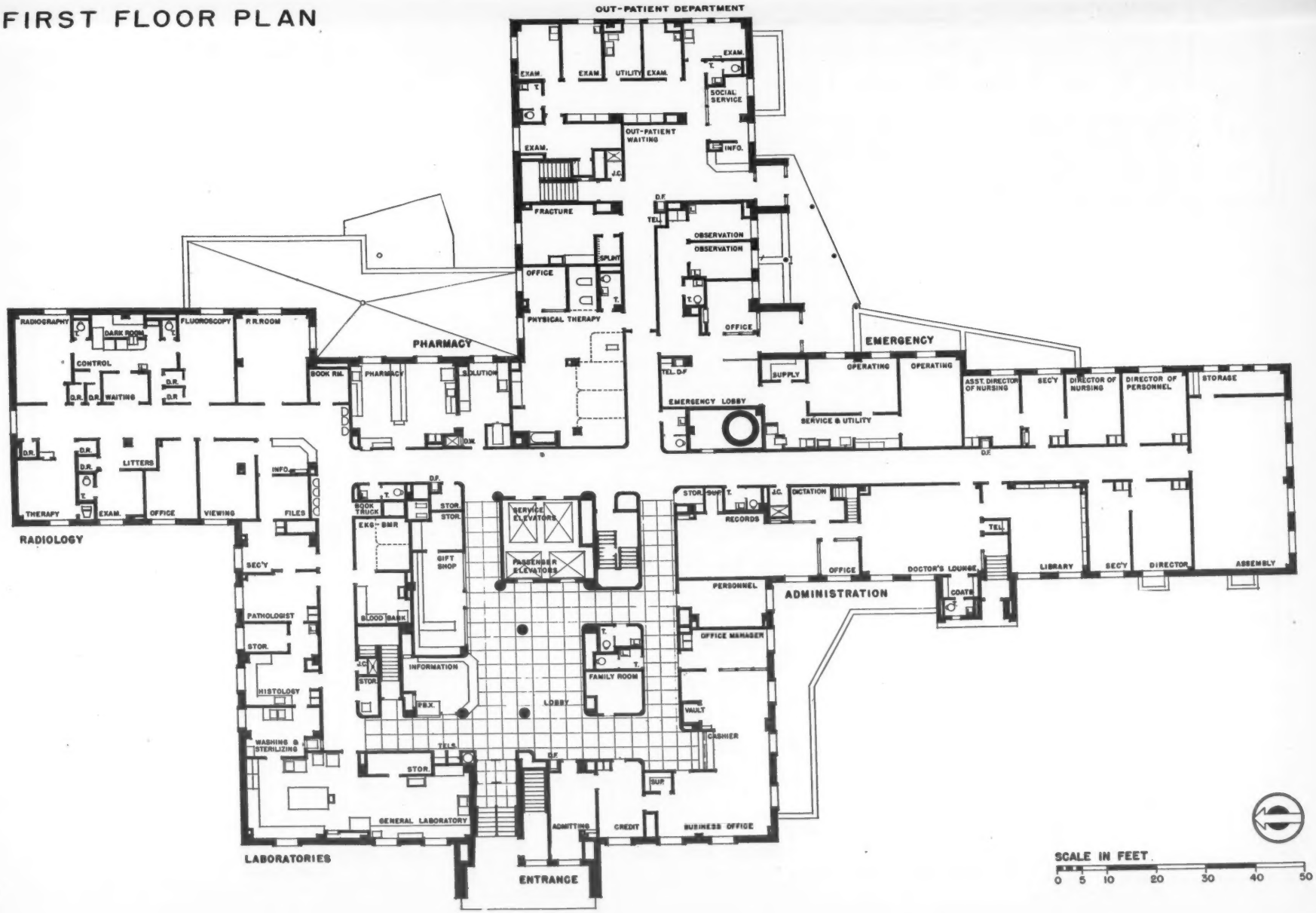


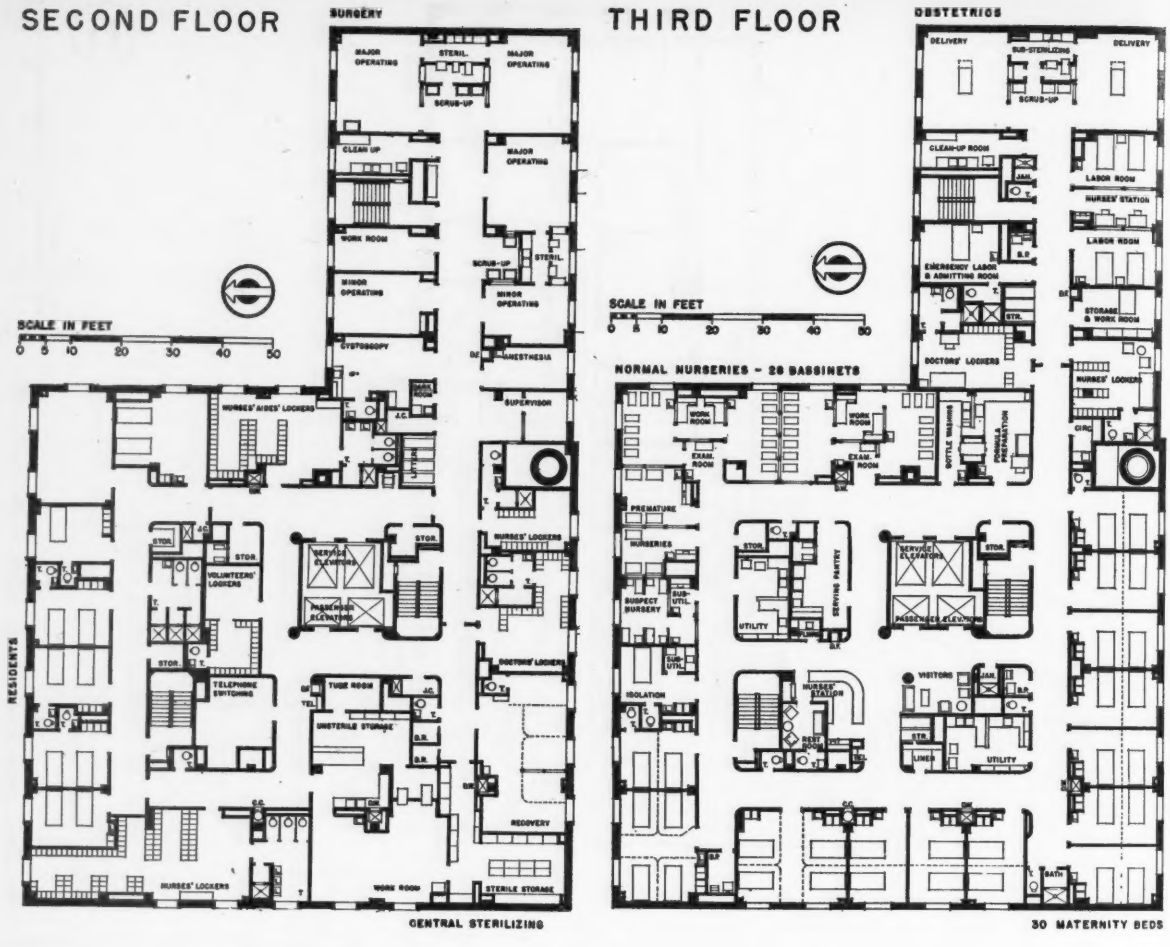
EUCLID-GLENVILLE HOSPITAL

FIRST FLOOR PLAN

EUCLID-GLENVILLE HOSPITAL

FIRST FLOOR PLAN





ture expansion. Patient areas expand vertically, service areas horizontally. To increase the number of beds, we shall add more floors on top of the building. Provision is made for this contingency in the original structural plans. To increase the x-ray, laboratory, outpatient department, surgery, delivery area or administrative facilities, we can easily extend horizontal additions.

Communication and transportation problems are greatly simplified by the square plan. Soiled laundry will be dropped by chute right into the soiled linen room of the laundry in the basement. Meals for patients will be taken off the kitchen production line and sent by tray conveyor straight to the diet kitchens, which are located centrally on each floor. Dirty dishes will be sent directly down from the floors to the central dishwashing room. Dumbwaiters will deliver most pharmacy orders, as well as those from the storeroom. A dumbwaiter for the delivery of sterile supplies goes from the "clean" section of the central sterile supply room to each patient floor, and another dumbwaiter brings nonsterile supplies from the floors back into the cleanup area of this department.

Pneumatic tubes for the delivery of requisitions and reports will be installed at a minimum of expense because of the compactness of the building.

The piping of oxygen to all patient rooms and to other points where it is needed is also done at a minimum of expense because of the minimal horizontal pipe runs and the uniformity of room layout throughout the building.

We are particularly pleased with the way in which the first floor developed. In addition to the usual administrative areas, we found it possible to have all adjunct facilities on this floor, so that private ambulatory patients and outpatients could be served without getting into the inpatient flow of traffic.

It is not anticipated that our community will require extensive outpatient service; so this area is of minimum size. It is in close proximity to departments that will serve visitors to it, such as physical therapy, pharmacy, x-ray and laboratory.

Because of extensive industrial development in Euclid, we are certain to have an active emergency department. Included in this department are two beds for observation purposes. The fracture room is nearby.

Only one extension to the square goes above the main floor, and this rises to the third floor so as to house the operating and delivery areas. There will be six operating rooms, three of them majors. Of the latter, one is convertible for major orthopedic surgery. The

surgical suite contains a six-bed recovery room.

Living quarters for residents and interns will be provided on the second floor until such time as other quarters are built for them. When that occurs, their rooms can be converted immediately to a 15-bed patient unit.

The third floor, which contains all maternity services, is arranged so that only one-half need be quarantined should an epidemic of contagion occur. Two delivery rooms will be served by three labor rooms of two beds each. If three patients are in labor at any one time, all will have rooms to themselves; but should more than three labor beds be needed, the rooms will be converted into semi-privates. The labor room nursing station is between two of these rooms for ease of observation and travel.

We shall have a number of small nurseries to conform with state and federal public health requirements. They are, however, compact for ease of operation and provide maximum protection against contagion.

The fourth and fifth floors are identical, one being for medical and one for surgical patients. They will be highly functional units, enabling us to provide a maximum of nursing service. The nurses' station in the center is fairly close to all patient rooms, and all service facilities that the nurses need are practically at their finger tips. Twin utility rooms each serve one-half of the beds, and, like the four bedpan sterilizers spotted strategically about the floor, they will serve to reduce nursing steps.

An oral communication system is to be installed between patients' rooms and the nursing station to accelerate service and reduce floor traffic. The centrally located serving pantry expedites quick service of food.

CONTROL OF NOISE

It is undoubtedly of importance to note that there will be very little traffic past the doors of the patients' rooms. Nurses, visitors and dietary maids need never pass the doors of more than three patient rooms and seldom more than one or two. This is felt to be a positive factor in noise control. Another factor assuring us of a lesser noise problem is the location of noise-producing activities in the core of the building, away from the patient rooms.

The sixth floor contains two basic elements. One is a 32-bed nursing unit, and the other is a pediatric unit. Because of the existence of a nearby hospital for babies and children, our pediatric unit is small, but it is easily expandable should the need occur. In fact, that is a particular feature of the square plan—space is very adaptable to adjustment at any time, and alterations may be accomplished with ease.

The 32 adult beds on the sixth floor will be used for "overflow" patients from the medical and surgical floors below. A solarium is also provided, but it is to be made adaptable for bed-patient use should this become necessary.

A large area is enclosed on the roof, next to the elevator penthouse, for use as an animal room. It is divided to provide for sterilization, an animal operating room and cages.

The basement is also a compact inclusive area. We have placed an integrated power plant in the building, a procedure that has many advantages. Naturally, this is less expensive to do than to build a separate building. It will be easy to expand if necessary. We shall have short steam and heat lines, which means economy in construction and operation. The engineer will be close to the power

plant, which will result in more supervision and less travel. Natural gas will be used for fuel, with an oil standby unit.

Other elements in the basement are equally distributed around the elevators for good access to vertical communication. The housekeeper, who also will supervise the laundry, is close to it, as well as being near the linen room and her employee locker rooms.

The kitchen is well situated in regard to food deliveries and storage, vertical transportation to the floors and cafeteria service for personnel. A snack bar is provided so that quick meals may be obtained by personnel and visitors.

Storage areas are not completely centralized, but they are close to the elevators and conveyor system. There is a stairway from the records storage room that goes up into the record room.

We were able to secure an ideal site for this new hospital. It is on the shore of Lake Erie and consists of a beautifully wooded 14-acre plot. It is completely away from noise and smoke, yet is only a few hundred feet from an arterial highway and a hub of public transportation facilities.

Existing contours of the site lent themselves admirably to enabling us to design a basement in which important work centers, such as the kitchen and dining rooms, would receive maximum natural light.

This acreage will provide nicely for adequate parking and recreational facilities. There will be parking areas for more than 100 cars, with designated areas for visitors, doctors and employees. Each of the special parking areas is near the entrance that is to be used by these persons.

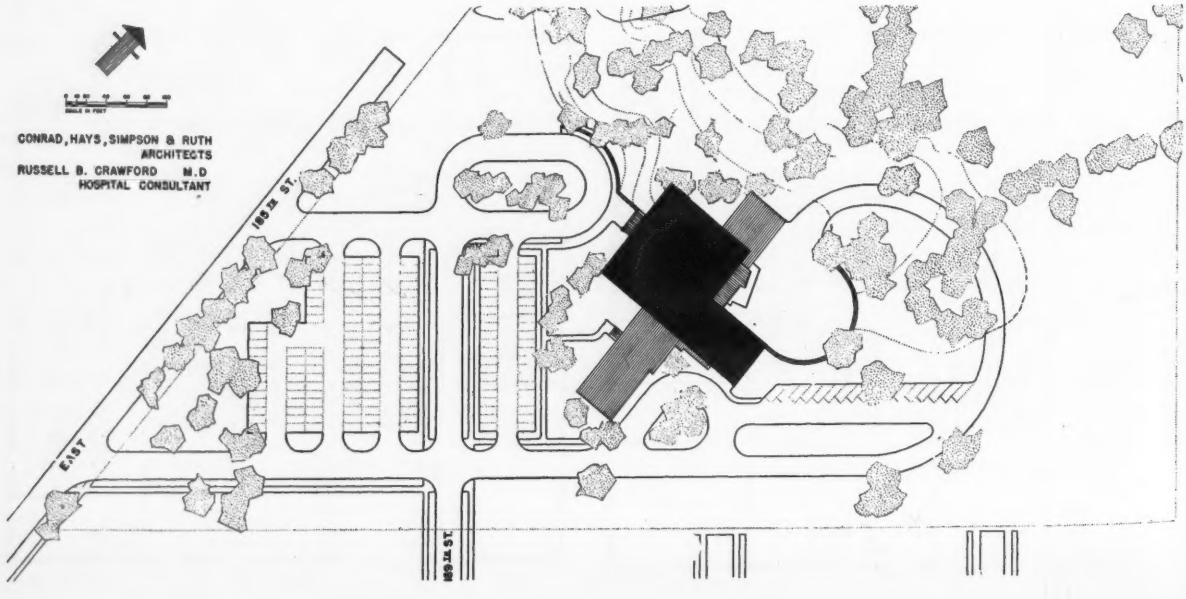
This hospital, to be named the Euclid-Glenville Hospital, will be the only general hospital in a population area of more than 100,000 persons, but it probably will be adequate to serve our community because some patients undoubtedly will continue to utilize the fine Cleveland hospitals that are nearby. A very unusual feature is that it will be staffed by the personnel and medical staff of our present hospital, which is several miles from the building described here. Euclid-Glenville Hospital will be located in Euclid, a suburb of Cleveland. A new group will operate the present Glenville Hospital.

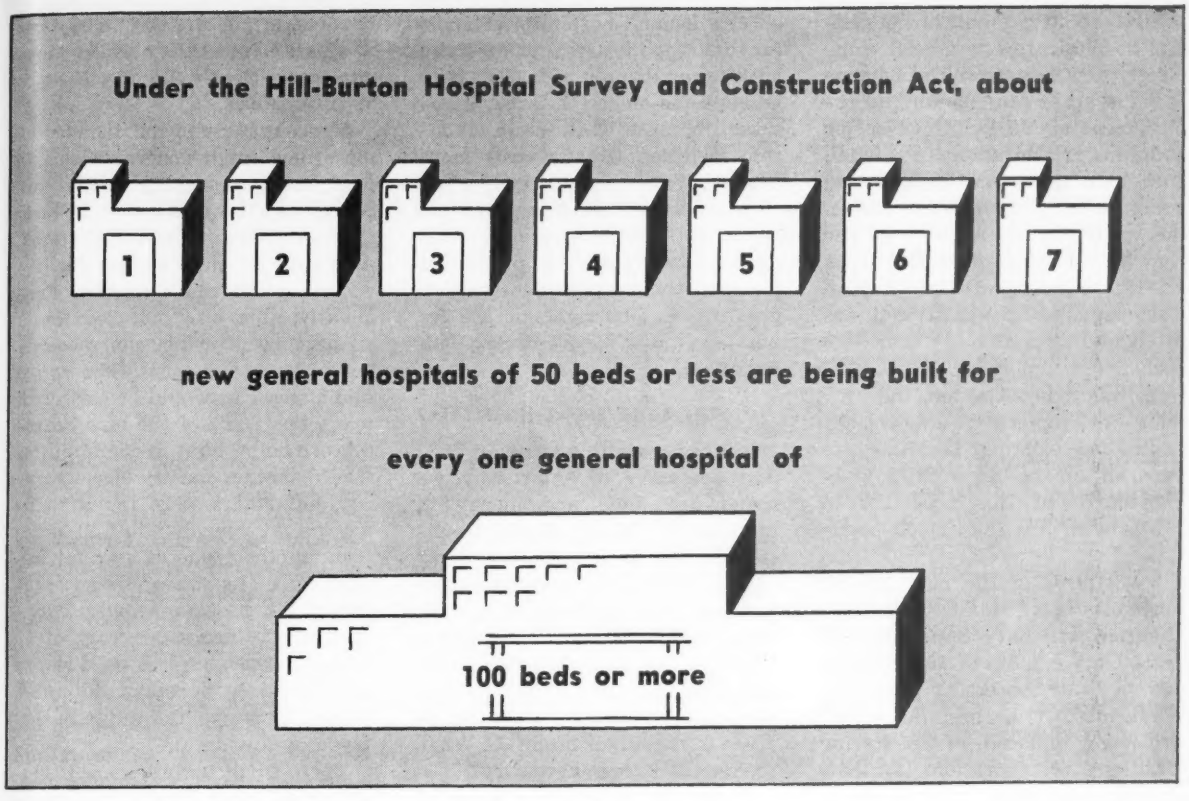
Following completion of a successful campaign to raise $1,000,000, we started construction of this $3,000,000 project in September. One million dollars has been allocated to us from the Greater Cleveland Hospital Fund, and the second million is available to us from the Ohio Department of Health under the Hospital Survey and Construction Act. The cost per bed will be a maximum of $15,000, but this figure includes the cost of an expensive site, completely new equipment, supplies, furniture, landscaping and architects' fees. The construction cost probably will be less than $12,000 per bed. We shall be able later, however, to add 48-bed floors at a cost of less than one-half of the above unit cost.

Our plan provides many construction economies in addition to those mentioned previously. It will have less exterior wall surface than a similar-sized rectangular hospital but will enclose a greater ratio of floor area. (It also reduces the gross floor area per bed.) It reduces the number of windows required, saving not only on construction cost but also on maintenance and heat loss. It reduces, to a noteworthy degree, piping, wiring and ducts in both horizontal and vertical runs.

To all persons who have been consulted on our square plan, it seems evident that this type of construction promises to be one means of combatting the high personnel expense incurred in rendering hospital service. I am confident that we shall be able to give high-quality patient care with fewer personnel than would be needed normally to do the same job.

It seems to us that this design offers many features that might be considered to advantage in hospitals of tomorrow.





Are we building too many small hospitals?

JOHN W. CRONIN, M.D.

IN SEPTEMBER 1947 the first project was initially approved for federal aid under the Hill-Burton program. This was for a new 50-bed general hospital in a southern town of fewer than 2,000 people. The nearest general hospital—a 40-bed facility—was 30 miles away. The nearest sizable hospital—one with 255 beds—was twice that far. The new hospital project was sponsored by the county, a fairly poor county compared with most others in the state.

This bit of history demonstrates that, from the very beginning, the Hill-Burton program has done its best to carry out its aim of building hospitals where they are needed most—in places where hospital care has not been within easy reach, where the area is rural, and where income is low.

In the three years that have passed since approval of this first project, nearly 1,500 others have been initially approved. Through these projects, more than 65,000 new hospital beds are to be provided. Total construction costs have now reached the one billion dollar mark, with the federal government contributing about one-third of this amount. Final approval now has been given to more than 1,000 projects. This means that blueprints and specifications have been approved, sites have been acquired and building preparations begun. But more important, as of today, 200 projects have been completed and are now providing community hospital or public health services.

WHAT ARE WE BUILDING?

Of all projects approved so far, more than three-fourths are for general hospital construction. (When we talk of hospital construction projects, we mean not only the building of an entirely new facility, but also the building of an addition or the remodeling of an existing hospital.) Next in order of number are public health centers —about 16 per cent of all projects. Then follow mental hospital projects—about 5 per cent of the total; tuberculosis projects—3 per cent; and chronic disease projects—less than 1 per cent.

As for construction costs, general hospitals again account for the major share—85 per cent—of the total, and for a like percentage of the federal share of the costs. Public health centers, while holding second place in number of projects, take last place in the share of construction costs, largely because of their relatively low cost per project.

So far, then, most of the emphasis in the program has been on general hospital facilities. Now, exactly what do we know about these projects? Just what are they, where are they, and how large are they?

Dr. Cronin is chief of the Division of Hospital Facilities, U.S. Public Health Service. Adapted from a paper presented at the American Hospital Association convention, Atlantic City, N.J., September 1950.

First, about one-half of the general hospital projects are for completely new hospitals. The balance is made up of projects for the replacement of old buildings or for additions or alterations to existing ones. Most of the new hospitals are being built in small towns and in the smaller cities. At least 70 per cent of the new general projects are in communities of fewer than 5,000 persons. Only 12 per cent are in communities of more than 10,000.

As might be expected, the projects for replacing, altering, or adding to existing hospitals are generally in the larger cities. Only one-fourth of this type are in towns with less than 5,000 population.

Two-thirds of the new general hospitals being built under the program will have fewer than 50 beds. Only one out of 10 will have 100 beds or more. On the other hand, most of the hospitals which are being replaced, or are having additions or alterations to their present buildings, are medium-sized or larger hospitals.

This, then, is the general pattern of the program. General hospital projects predominate. Half of these are for completely new facilities which, for the most part, are in small towns. Most of the new facilities will have fewer than 50 beds and thus will fall into the category of "small" hospitals.

Nearly two-thirds of the new "small" facilities will have from 20 to 35 beds. Some of the even smaller projects, with 10 to 15 beds, probably should be called community clinics rather than general hospitals. Nevertheless, they do meet specifications for a hospital in that they will provide 24-hour service.

Practically none of these new small hospitals are being built in large population centers. Two-thirds of the new projects calling for fewer than 50 beds are in towns of less than 2,500 people. Nearly all are in towns of less than 5,000.

While the small hospital predominates among all new general hospital projects, there is a somewhat different story in the distribution of federal construction funds. Little more than one-third of the federal money being used for all new general hospital projects is for small facilities, that is, for those with fewer than 50 beds. This is to be expected since the larger institution, because of its more elaborate facilities, usually costs more per bed than the small institution.

In this brief review, one fact stands out: The small general hospital is occupying a prominent place in the hospital construction program. Is this right, or are we building too many of these small facilities?

WHY BUILD SMALL HOSPITALS?

In answering this question, it is first necessary to know why we spend *any* time and money in building 25, 30, or 40-bed hospitals. It is true that they are not utilized as fully as larger facilities, because the small hospital does not have the flexibility of use that is found in the larger hospital. It is also true that they do not provide the variety of services that can be given in the larger hospitals. What, then, makes them necessary?

Under the Hill-Burton program, each of the states has investigated its hospital facilities situation. Each has outlined hospital service areas where general hospital facilities should be available to the areas' residents. Each has given high construction priority to those areas where facilities are needed but are completely inadequate or entirely lacking. The majority of these are small rural localities. As a result of the incentive given under the Hill-Burton program, communities in many of these "service-needy" areas have raised funds and submitted approved plans for local hospitals. Generally speaking, the hospitals planned are small usually because the expected immediate demand for hospital care does not warrant a larger facility. In some instances community funds have placed a limit on the size of the facility that can be built.

So far, about 350 small general hospital projects have been approved. Well over one-fourth of these are in service areas which heretofore had no general hospital; another one-fourth are in areas that have no facilities which meet the state standards for an acceptable hospital. The remainder are in areas where some facilities exist but where they are completely inadequate to meet the need for hospital care. Nearly all of these are in rural areas.

A recent study of the distance of these new small general hospitals from the nearest other facility included new hospitals with 25 beds or less and covered about 20 states. As a rule, the next nearest facility was about 25 miles distant. Frequently, this was found to be a nonacceptable institution, according to state standards. The range in distances, as would be expected, was wide. Some of the new hospitals are being built in communities where another facility already exists, but others were found to be anywhere from 100 to 150 miles from another general hospital, regardless of its size or its acceptability. When distance was measured to the nearest facility of 50 beds or larger, the average distance was found to be about 45 miles. Again, of course, the range in distances was wide.

These small hospitals are bringing or will soon bring *some* hospital service to areas where the need has been critical. They have the potentiality of growing into more effective-sized institutions when demand for service increases or when additional funds for expansion become available. Our data from the state plans and from the project applications show that, on the average, the approved new hospitals of fewer than 50 beds will meet only about half the number of beds needed in their areas.

For many years we have been talking about the shortage of physicians in our smaller towns and rural areas. We all know why this shortage exists. Physicians naturally settle in communities where they can make the best use of their medical training. Modern medical training puts heavy emphasis on the use of precision instruments in diagnostic and treatment facilities. What chance has a small community, without any type of hospital or clinical facility, to attract and keep a doctor? Few physicians willingly settle in small towns, away from the hospital equipment they need and depend upon and cut off from other medical connection. Few are willing to accept medical isolation.

(Continued on page 148)

Old age and survivors insurance is one of many aspects of this federal program.

Social security: what it means to the hospital

ALBERT V. WHITEHALL

RECENT ENACTMENT of H.R. 6000 brought an estimated 11,000,000 new workers under the protection of the federal social security system. Included among these was an estimated 370,000 employees of nonprofit hospitals. But social security coverage is voluntary for nonprofit institutions and for their employees. That is, the nonprofit institution must waive its exemption from the special provisions of the Internal Revenue Code regarding social security contributions; and this waiver certificate must be signed by two-thirds of the employees.

Mr. Whitehall is director of the American Hospital Association's Washington Service Bureau.

The waiver certificate does not affect the hospital's tax-exempt status. It does not involve unemployment insurance, nor does it establish a precedent for unemployment compensation coverage, although Congress tentatively plans to look into that subject soon.

GOVERNMENTAL HOSPITALS

The social security amendments of 1950 may provide old age and survivors insurance coverage for hospitals owned and operated by units of state or municipal government. The Constitution, however, prevents the federal government from imposing any compulsory program upon any state government or upon any of its political subdivisions.

This prohibition is overcome by authorizing the federal government to enter into voluntary contracts with the states for coverage of state employees. But where state or local governments already have retirement or benefit systems, the federal program does not apply. It is thought that most of the states may require enabling legislation to permit the state government or other responsible official to sign contracts with the federal government for OASI coverage.

WAIVER CERTIFICATE

The hospital itself must initiate action for coverage of its employees by executing a form of waiver certificate. These forms are being prepared now and probably will not be ready until about December 1. After having the waiver certificate signed by properly authorized officers, the hospital then must give every employee the opportunity to sign it too. But three groups of employees are specifically excluded by the act. These are (1) student nurses, (2) interns and (3) part-time workers earning less than $50 in a calendar quarter.

A regulation of the Social Security Administration says that work performed by "resident doctors" is not included in the ex-

Questions and answers about social security

Question: What is our first step in providing old age and survivors insurance for our employees?

Answer: Get in touch with your local social security field office. It may be listed in the telephone book under U. S. Government, or the local post office can provide the address.

Question: When can we begin to enroll our employees for old age and survivors insurance benefits?

Answer: Probably not much before December 1. Forms of waiver certificate are being prepared and procedures are being worked out. The American Hospital Association will publicize this information when the forms are available.

Question: Must employees actually sign the certificate waiving the hospital's exemption?

Answer: Yes. The law says the certificate must carry the signature, address and social security number if any of two-thirds of the employees; and, of course, a responsible official of the hospital must sign the certificate on behalf of the institution.

Question: What if we cannot get the certificate signed and filed before January 1, 1951?

Answer: You may file the certificate at any time, but payroll deductions and employer contributions and OASI coverage do not start until the beginning of the calendar quarter following the date of filing the certificate.

Question: Does participation in the old age and survivors insurance program jeopardize the tax exemption of nonprofit hospitals?

Answer: No.

Question: Does old age and survivors insurance include unemployment compensation?

Answer: No; they are separate programs. Congress plans to study the unemployment compensation at an early date with a view to improving and expanding it. The issue of hospital participation in unemployment compensation will arise at that time; not now.

Question: May employees over 65 sign the certificate and get OASI benefits?

Answer: Yes, an employee over 65 not receiving OASI benefits would be wise to sign. He can be eligible for benefits after six calendar quarters of coverage.

Question: What if he is already drawing social security benefits?

Answer: An employee now drawing social security benefits might be wise to stay out. He cannot receive social security benefits in any month that he earns $50 or more in covered employment. He could earn as much as he wishes in employment not covered by social security. Or, if he is more than 75 years of age, he could earn as much as he wishes in any employment, covered or not.

Question: What about student nurses?

emption provided for interns. It is probable that the exemption of workers earning less than $50 in a calendar quarter may need to be clarified.

It has not been decided where the waiver certificate will be filed. There are 578 field offices of the Social Security Administration scattered across the country, and any of these might handle it. Or it may be that the local collector of internal revenue will receive it.

DEDUCTIONS AND CONTRIBUTIONS

When the certificate has been filed, coverage does not start until the beginning of the next calendar quarter. Payroll deductions are made on the first $3,600 of annual wages for the calendar years 1951 to 1953, inclusive. The rate is 1½ per cent each for employee and employer, making a total of 3 per cent. For the calendar years 1954 to 1959, inclusive, the rate is 2 per cent on each. Each five years thereafter the rate increases until 1970, when it reaches 3¼ per cent for employees and 3¼ per cent for employers. Actuaries have figured that the benefits promised under social security should cost at least 7½ per cent of wages. But lower rates from now until 1970 are possible because it is expected that fewer people will draw OASI benefits now than when the system matures.

SOCIAL SECURITY CARDS

Each employee covered by social security must enroll in the system by applying at the local social security field office. He will be given a card bearing a social security number. The worker retains this number all his life. His payroll deductions and the employer contributions will be credited to his account bearing this social security number. Therefore, a hospital employee who has worked in covered employment previously should not apply for a new number but should give the hospital his present social security number. If he has lost his card or forgotten his number, he may apply to the local social security field office for it.

Although social security numbers must be obtained from the local social security field office, it is possible to have application forms filled out and signed in the hospital, so that the entire transaction can be handled by mail. The hospital probably can arrange this by telephoning the local social security field office.

BENEFITS

Hospital employees understandably may be reluctant to sign up for old age and survivors insurance payroll deductions unless they can be shown what a bargain they are getting. Even though insurance specialists have commented that the benefits offered through old age and survivors insurance could not be obtained for less than

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Answer: The law specifically exempts student nurses.

Question: What about interns?

Answer: The law specifically exempts interns, too.

Question: What about residents?

Answer: Regulations state that the exemption of interns does not apply to work performed by resident doctors.

Question: Are part-time workers covered?

Answer: Not in any calendar quarter in which they earn less than $50 in a nonprofit institution.

Question: Is the value of maintenance included as the basis for payroll deductions and employer contributions and monthly benefits?

Answer: Social security is figured, we are told, on the same income that is used for figuring income taxes. If the employee pays income tax on the value of maintenance, then his social security deductions are based on the same figure. The American Hospital Association is presently seeking clarification of this general rule. The decision of the Bureau of Internal Revenue will be announced to the field when it is reached. Meanwhile, the general rule is that maintenance received by the employee for the convenience of the employer is not subject to income tax.

Question: May employees change their minds about participating in old age and survivors insurance?

Answer: Yes. If they refuse to sign the certificate before it is filed, they may add their names to a supplemental certificate which may be filed at any time within 30 days after the end of the first quarter of coverage of the institution. Besides, the law states that all new employees are automatically covered. It seems possible that an employee might resign and be rehired, thus becoming covered automatically. But once in social security, they can get out only by getting a job where social security does not apply.

Question: Are new employees covered if the hospital refuses to file the certificate, or if signatures of two-thirds of the employees cannot be obtained?

Answer: No.

Question: Should we urge our employees to get social security cards at once?

Answer: Not necessarily. You may be able to make a deal with the local social security office to handle the whole business by mail. If so, they would send application forms for employees to sign. The hospital could send these forms back, and the social security cards would be mailed to the employee either at home or in care of the hospital.

Question: What if an employee already has a social security card?

Answer: He should not get another. He carries the same social security number all his life. Women simply change the name on their social security account when they marry, but they continue to carry the same social security number.

Question: What if the social security card is lost?

Answer: Another card with the same number can be obtained from the local social security field office.

Question: Why should employees be interested in signing up for old age and survivors insurance?

Answer: For one thing, it is a good bargain. The small deduction from the payroll is matched by an equal contribution from the employer. Even this premium would not begin to purchase the same protection under commercial insurance. It is estimated that even the 7½ per cent total contributions that will be effective after 1970 may not be adequate to finance the whole cost of the benefits. The survivors benefits alone—the death benefit payable in a lump sum and the benefits payable to surviving children, spouse or parent—provide a very desirable protection. And, of course, it is good to have a monthly income, however small, upon retirement.

Question: If our hospital already has installed a pension system of its own, can we afford to pass up social security?

Answer: No. Most pension programs are devised so as to fit in with the OASI program of social security. This is particularly true of the National Health and Welfare Retirement Association program evolved by the American Hospital Association. Its benefits are calculated to make retirement benefits more adequate.

7 to 10 per cent of wages, the cost to the employee starts out at just 1½ per cent and rises to a maximum of 3¼ per cent in 1970. The hospital's own contribution of an equal amount in effect doubles the worker's investment.

The old age and survivors insurance benefits fall into the following classes:

1. Old age insurance—Monthly benefits to persons over 65:
   (a) To the worker himself —one primary benefit;
   (b) To the worker's spouse —50 per cent of the primary benefit;
   (c) To the worker's surviving spouse—75 per cent of the primary benefit.
2. Death benefit in a lump sum —Three times the primary benefit.
3. Survivors insurance—Monthly benefits payable to:
   (a) Dependent children under 18—75 per cent of the primary benefit. (If more than one child, each gets slightly less.)
   (b) Surviving spouse (or divorced wife) living with dependent children under 18—75 per cent of the primary benefit.
   (c) Dependent parent over 65 (if no surviving spouse or dependent children)—75 per cent of the primary benefit.

A primary benefit is simply the amount of old age benefits paid to the retired worker himself each month. Under the new law, the monthly primary benefit is 50 per cent of the first $100 a month of average wages in covered employment, plus 15 per cent of the next $200. For example, if a worker's average wages in covered employment were $200 per month, the monthly primary benefit would be $65. All other benefits would be based on this figure.

There is much in the literature about conversion rates and increment factors, but newly covered hospital employees usually may ignore these. The conversion tables show the increased payments to persons already receiving social security benefits. The increment factor is part of the formula for figuring benefits under the old law. The old formula provided much smaller benefits but added 1 per cent for each year in covered employment. Some employees who worked many years under the old law might have built up benefits greater than the new formula provides and in such cases they may choose the formula that pays them most.

ELIGIBILITY

A quarter of coverage is a calendar quarter beginning January 1, April 1, July 1 or October 1, in which the worker earns at least $50 on which payroll deductions and employer contributions are made for old age and survivors insurance. When he has earned 40 quarters of coverage, he is *fully insured* and eligible for all benefits of the system at any time thereafter. But if he has less than 40 quarters of coverage, he may be eligible for old age benefits if he has quarters of coverage equal to at least half the number of quarters that have elapsed between January 1, 1951, and the time of his retirement, with a minimum of six quarters of coverage.

But he establishes eligibility for death benefits and survivors benefits if he is *currently insured,* that is, if he has earned six quarters of coverage during the last 13 quarters prior to death.

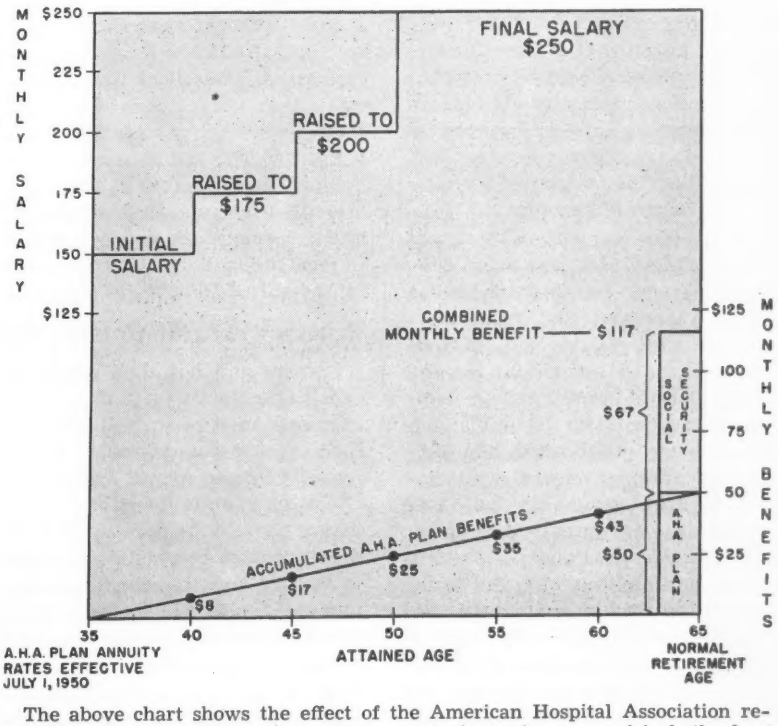
WORKERS OVER 65

Hospitals traditionally have many workers in the older age group. Workers past 65 are in a most fortunate position under the terms of the 1950 amendments.

In the first place, the worker over 65 may choose whether or not to be covered by OASI. If he is not already eligible for OASI benefits, he may sign up just like any other employee, and after working for a year and a half he may become eligible for old age benefits. [*Please see next page.*]

Approximate benefits—American Hospital Association retirement plan combined with social security

(For a woman participating from age 35 to 65 and receiving promotions.)



The above chart shows the effect of the American Hospital Association retirement plan and social security for a woman becoming covered in both plans at age 35 and continuing until her normal retirement age at 65, with salary ranging from $150 to $250 monthly. The combined vertical column at age 65 shows the approximate benefit she would receive from both plans.

If he has earned quarters of coverage in other employment prior to 1951, he may use as many of those quarters as he needs to make up the necessary minimum of six quarters of coverage for eligibility. Such quarters of coverage may be earned before and after 1951 and before and after age 65.

If the worker over 65 is receiving OASI benefits, those will be cut off if he earns more than $50 per month in covered employment. (Under the old law, the maximum was $15 per month.) Under these circumstances the worker over 65 may continue working in the hospital without participating in the system and earn as much as he wishes—and still draw benefits. But, of course, if his employment is terminated he will be automatically covered if he goes to work in another hospital that has OASI coverage or if he is rehired.

Workers over 75 may earn any amount of money in covered employment and still get full benefits.

OTHER ASPECTS

Social security is well established as a factor in our economy. When first enacted in 1935 its advocates hoped that in time the entire population would be protected by the old age and survivors insurance program, entirely financed by a special tax upon payrolls. This they called the "contributory program" of social security.

With the recognition that old age and survivors insurance coverage would be incomplete for many years and that many persons would require aid without being able to qualify under the "contributory program," a supplemental program of public assistance was established. The federal government offered grants-in-aid to state programs for three categories of public assistance: (1) Old age assistance; (2) aid to dependent children; (3) aid to the blind. The 1950 amendments added another category: (4) Aid to needy permanently and totally disabled. The Children's Bureau also carries on its child welfare program, its crippled children's program and its maternal and child health program with appropriations authorized under the act.

The federal government, then, assists state programs for these purposes, provided they adhere to general standards laid down by the federal government. The states also must contribute financially.

INCREASE IN FUNDS

Most of the maternal and child health services are aimed at health promotion—for example, prenatal clinics, home visits by public health nurses, well-child clinics, immunization, and medical and dental services for school-age children. Now there will be $16,500,000 instead of the former $11,000,000 in federal funds available for maternal and child health services each year, and each state must match half of the federal grants.

Services for crippled children will increase as a result of a new $15,000,000 federal authorization in place of the old allotment of $7,500,000. These funds help provide medical care, hospitalization and convalescent care for crippled children. Again the states must match half of these federal funds. Last year about 200,000 crippled children received services under this program.

Child welfare services now will receive $10,000,000 in annual federal grants instead of the $3,500,000 authorized for each of the past four years. Each state will receive a flat $40,000 and will share the balance according to a variable-allotment formula. Each state must assume some of the cost of services in local areas, but no fixed amount of federal aid must be matched.

DIRECT PAYMENT TO HOSPITALS

Doctors and hospitals providing care to recipients of public assistance now may be paid directly for such care by state agencies, A ceiling of $50 per month remains in effect on public assistance; and under the aid to dependent children program this ceiling amounts to $27 per month each for mother and child, plus $18 for each additional dependent child.

Serious study now is being carried on as to how state agencies may accomplish the most good for their beneficiaries under the more liberal terms under the new federal law. There have been suggestions that welfare agencies in the state might purchase prepayment insurance through Blue Cross or other media for assistance recipients. This is bound to be met with a counter proposal that states be permitted to accumulate the difference between cash payments and the federal ceiling into a pool of funds to be used for welfare clients in need of hospital or medical care. There is another suggestion that the ceiling of $50 per month might still permit substantial reimbursement for a severe illness if payment were permitted in small amounts, to be stretched out over several months beyond the terms of actual illness.

How may hospital people demonstrate their interest in these programs? First, there is the probable necessity of supplementary legislation to increase state appropriations for these programs. Federal funds generally are available only to the extent that state legislatures provide matching funds or other financial contributions. Federal limitations on hospital care do not restrict the state from going farther. Many already have done so.

HOSPITAL STANDARDS

The 1950 amendments also require that any institution providing care for public assistance beneficiaries must meet standards established by the state. Many state hospital licensing laws already cover all types of hospitals using the broad definition suggested in the model law recommended by the American Hospital Association. But many states and local governmental bodies were unwilling to include their institutions in the first enactment of the hospital licensing law. These will be ineligible to provide care for public assistance recipients until the hospital licensing law can be amended.

Hospital administrators with vision and understanding of the needs of their community will recognize that the 1950 amendments to the Social Security Act will offer many opportunities for the provision of additional services to public assistance recipients. Hospitals should be alert to see that these improvements in the federal law are supplemented by proper state action.

"Because of developments in this air-atomic age, the United States can no longer be free from the danger of a sudden devastating attack against the homeland.

"The greatest deterrent to such attack is the knowledge on the part of a would-be aggressor that we have the power to destroy him by retaliatory action.

"Since there can be no absolute military defense, an effective civil defense is vital to the future security of the United States because it might provide the means whereby this country, if suddenly attacked heavily and without warning, could get up off the floor to fight back.

"An enemy attack would presumably be aimed at the great metropolitan areas, at the cities and towns, at the country's most critical targets.

"Such an attack would be against all the people of the United States, and therefore defense against it must require the coordinated effort of the whole nation.

"It is expected that such an attack would be partially successful. Whether it would succeed in destroying America's productive power would depend in the main on the organization and functional efficiency of the country's civil defense. This vital element has been missing in our system of national security."—Introduction to *"United States Civil Defense."*

The hospital's role in a plan for survival

THE CHAIRMAN OF the National Security Resources Board, W. Stuart Symington, has submitted to President Truman a document that carries in it a plan for national survival.

Lodged in a 162-page booklet, entitled "United States Civil Defense," are the beginnings of real, constructive thinking on civilian protection against the weapons of modern warfare.

Without attempting to spell out the myriad details that must sooner or later fall into place, the new plan describes a solid foundation upon which state and local governments can erect appropriate civil defense structures.

Stating that the federal government "cannot and should not" operate state and local civil defense systems, the plan calls for a system in which the federal government remains in the background as adviser, teacher and coordinator.

Hospital administrators, without doubt, will be called upon to assist in the planning of effective civilian defense for their own regions. They will be asked to join hands with policemen, firemen, social workers, engineers, industrialists, truck fleet operators, radio specialists, atomic scientists, and local governmental authorities—all of whom will be woven into effective disaster teams.

Plans call for the creation of a new federal agency—the Civil Defense Administration—to assist in preparation of state and local civil defense teams. This agency would establish federal regional offices to serve as links between the agency and the states and to coordinate civil defense operations in the event of a national emergency. Although this agency would not exercise operational control, it would have authority over funds and materials supplied by the federal government. The civil defense agency also would establish and supervise air-raid warning systems and special communications networks.

A nationwide civil defense training program will be developed by the federal government through the establishment of a "staff college" for key personnel from states and cities. States, in turn, will organize and operate their own programs with federal aid and guidance. Local governments, with state assistance, will train most of the civil defense workers and the general public.

Within each state or regional defense network, a number of different kinds of specialized services will be needed. The civil defense plan recommended by the National Security Resources Board lists a total of 17—one of which would take in the services to be provided by hospitals in a disaster.

HEALTH SERVICE

This category is called the "health service" and includes, in addition to regular hospital facilities, first aid and ambulance services; provisions for quickly converting schools and auditoriums into improvised hospitals; a system for distribution of health supplies; emergency laboratory services; sanitation services; health transportation services; morgue services; veterinary services, and a large embryo activity entitled "Defense against Special Weapons."

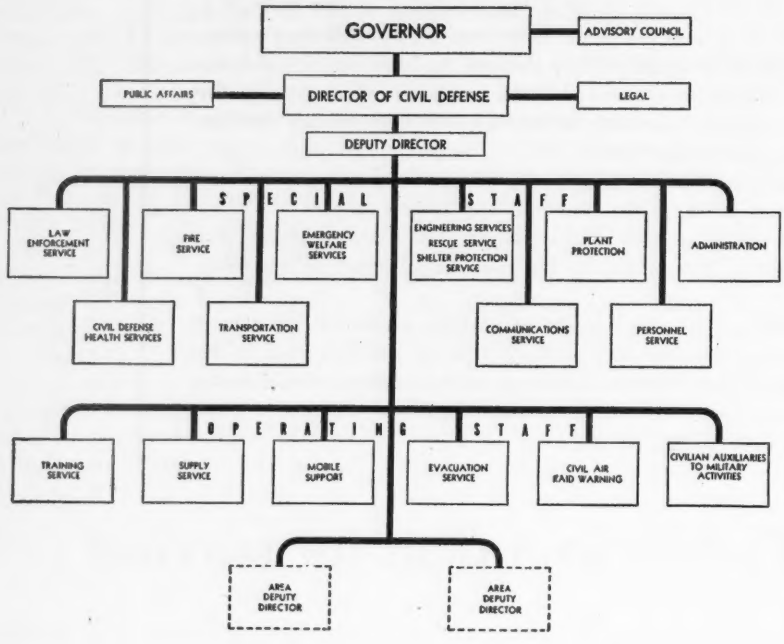
The last named involves special measures which must be taken to enable civil defense organizations to deal with problems arising from atomic, biological and chemical warfare.

Three types of emergency hospital systems are recommended as the hospitals phase of civil defense health service:

1. Improvised hospitals: Preplanning here would involve a complete inventory of facilities

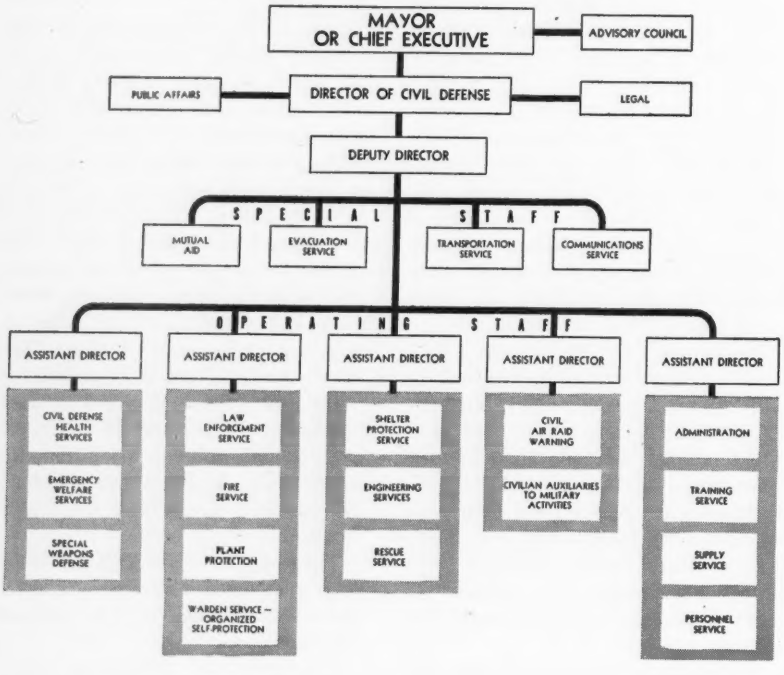
SUGGESTED MODEL

STATE ORGANIZATION OF CIVIL DEFENSE



SUGGESTED MODEL

LOCAL ORGANIZATION OF CIVIL DEFENSE



around critical target areas to determine available space which could be converted to hospital use. These usually would be school buildings. Use of hotels and apartments is not recommended.

Emergency equipment such as beds, instruments, and medical supplies would be placed in condition for ready shipment from storage points to equip improvised hospitals. Staffs, including volunteer workers, would be drawn from nearby areas to treat cases of shock and burns and to perform surgical procedures.

2. Undamaged hospitals in the disaster area: These might be reserved and staffed for casualties which would require major surgical procedures of a type too difficult to be performed in improvised hospitals.

3. Existing hospitals in nearby and distant communities: These would be used to handle patients who could safely be transported to them. People exposed to dangerous amounts of radiation, but with no other significant injuries, would be transported to the distant hospitals in designated taxis, buses, or private automobiles, in order to assure them adequate treatment at the onset of radiation sickness. Vehicles employed for this purpose would be suitably labeled and would be monitored frequently for radioactivity.

PLAN BACKGROUND

The United States Civil Defense Plan has behind it 10 years of world thinking, planning and experience. Full use was made of the experiences of civil defense organizations in this country and in England during World War II.

It forms the groundwork for a series of educational, administrative and technical manuals soon to be published. These manuals will spell out in considerable detail the operating aspects of the program and the functions of the various services involved.

More than 125,000 copies of "United States Civil Defense" are now being distributed to key agencies. Others may obtain copies from the Superintendent of Documents, U. S. Government Printing Office, Washington 25, D. C., for 25 cents each.

By means of a group of specific, down-to-earth suggestions, a California administrator describes methods for . . . .

Injecting vitality into the local hospital council

JOHN H. GORBY

WHAT IS A HOSPITAL COUNCIL? On a local level it is an organization of hospitals in an area small enough to insure that each hospital can physically meet regularly with its neighbor to discuss mutual problems of a purely local nature.

The major problem of an individual hospital is to provide maximum utilization of its services at minimum possible cost. This definition might serve also as a major objective of a council, its minor function being to serve as the correlating medium between hospitals and the professions, public health and welfare agencies and Blue Cross. Through the council, the public health program and hospital medical care in the community should be coordinated and plans developed for effective service.

The council objective can be broken down into three broad spheres of activity: (1) Effective administration, (2) cooperative planning and (3) community service.

There are many specific projects that may be easily approached by the technique of a small local council. They are practical, can be done with minimum effort, will all result in an improved administration and cutting of costs of service, and will render a real service to the community. These problems are limited only by the cooperative spirit evidenced by the group.

Charges for service should have some sort of relation to costs of that service. Locally, rates should be more or less uniform for comparable services. If one hospital has very low rates, the council should learn how the hospital establishes and operates on these rates. Any discussion of rates should be held at an adjourned session, with no minutes kept.

PAY ROLL AND PERSONNEL

In regard to pay roll and personnel, the council should try to set up uniform pay rates, vacations and sick leaves in the area. Employment turnover may be lessened by refusing to hire an employee who leaves a member without good reason, but "blacklisting" anyone is a bad policy. It is not only illegal but an open invitation to union organizers.

Although administrators have public relations fairly well under control, the local council is an ideal medium for instruction of personnel by a skilled public relations counselor. He can talk to the telephone switchboard operators, admitting clerks and others on the best way to meet the public.

For a public education project, the council should have one person as a "committee of one" to handle releases from the state public education committee. The council can feed in the local color to make this news really local, as well as attractive to the local press. Mention of the local medical society once in a while is a good policy. The medical and hospital groups often are faced with a joint problem.

One member of a local council can volunteer to act as a central clearing house for credit data. It might be possible to include the local doctors and dentists. Most people who owe a hospital also owe a doctor or a dentist. If a local collection agency is used, the bad accounts of all hospitals can be pooled and the total submitted to the collection firms for bids. The volume will bring the usual 50 per cent fee down to 25 or 30 per cent.

Group purchasing could be an excellent project for a local council if handled properly. The start should be made with only one item. As experience is gained, the number of items can be increased. The whole field of hospital purchasing, however, cannot be covered. Most of the plans that have failed took on too many items at one time.

The council can do much in improving standards for members.

First, it should be sure that every member is registered with the American Medical Association.

Second, it should urge every member to join the American Hospital Association and the state and regional associations. The benefits far exceed the cost.

Third, it should work toward full approval by the American College of Surgeons.* The standardization program of the college is designed for small hospitals as well as large.

Fourth, it should urge attendance at institutes, state and regional conventions and meetings of like nature. Also, eligible administrators should be urged to apply for admission to the American College of Hospital Administrators.

GROUP LAUNDRY

Another good cooperative project is a group laundry. One example of this is that of three California hospitals with a combined bed capacity of 124 beds. None could afford the cost and maintenance of its own laundry. Together they could. One contributed an old panel truck, and another an old warehouse building. They shared the costs on the basis of pound

Mr. Gorby is administrator of La Mesa (Calif.) Community Hospital and past-president of the Hospital Council of San Diego County. Adapted from a paper presented before the Association of California Hospitals, November 1949.

*The American College of Surgeons has announced that its approval program will be discontinued. At its Atlantic City convention in September the American Hospital Association's House of Delegates voted to operate its own approval program, which may or may not be that now operated by the college.

usage, employing the framework of the council to serve as bookkeepers. Today they are having their laundry done at a saving of 3½ cents a pound.

Another thought is that one of the larger hospitals with its own laundry could, at slight cost, increase its own capacity to do the laundry of a smaller hospital. Or, a medium-size hospital might find itself with a laundry too big for its own use. A skilled laundry man could survey this at very little cost.

The small hospital, by itself, cannot afford a registered medical record librarian. Three or four hospitals could employ a librarian jointly. The American College of Surgeons requires medical records to be under the control of a registered librarian, but she does not have to be on duty eight hours a day to meet this requirement.

Each hospital wants the finest sort of medical staff organization it can have. The experience of the large hospital administrator can help the head of the smaller institution. The council machinery can be employed to discipline the medical maverick who conforms to no one.

Compensation insurance companies in California have unmercifully gouged hospitals on rates and will continue to do so. They hide behind an alleged rate schedule approved by the Industrial Accident Commission, which that body disaffirms. Copies of all rates should be filed with each carrier. If the companies do not pay, they should be sued. Hospitals can work together on this.

ALLIED INSTITUTIONS

In relations with allied institutions, the council can encourage rest homes and sanatoria in the area to organize their own group and then maintain cordial relations with its officers. Contact also can be established with the osteopathic hospital if there is one. This does not mean that such a hospital is formally recognized or made a member, but the osteopathic hospital *is* a hospital. The public as a whole fails to draw the fine line of distinction, and we are dealing with the public. The contact can be limited to the telephone, but it is a valuable one.

Uniform use of prepayment plan contracts in the area will eliminate friction with the pathologists and radiologists. There always will be a certain amount of misunderstanding until each hospital is on the same basis.

Standardization of surgical packs is an ideal local council project. It protects each member in the event of a heavy surgery schedule or breakdown of sterilization equipment.

An earthquake or explosion can send several hundred casualties to a hospital suddenly. In most cities the World War II civilian defense set-up has ceased operation. New plans now are being developed in many areas. The council can set up a plan for its member institutions and work with county officials on an over-all plan.

GROUP PHARMACY

Another council project could be built around a group pharmacy and dietitian. Two or three small hospitals can use one registered dietitian, although each could not afford one by itself. The same situation is true for a pharmacist.

The Public Health League is the political arm of doctors, dentists and hospitals in California, and such organizations should not be ignored by hospitals. They are a means of combatting the forces working against such institutions. If there is no chapter in the area, the local hospital council can assist the county medical society in forming one or in reactivating a decadent group.

The organization and function of the council is one of the most important points in the entire council plan. Officers must be chosen who will plan and then work to carry out the plan. The very nature of a local council program calls for aggressive, hard-hitting work.

The secretary, next in importance to the president, must understand that his job involves correspondence, the writing up of the minutes, the preparation of the agenda, and such other work as the president may direct.

There also should be a clear understanding by the officers of the place occupied by a local council in the hospital organization set-up. Problems discussed and work done must have local significance only.

Meetings should be held at regular intervals, at least every 60 days, and should be subject to call by the president at any time. Regularity of meeting is perhaps equally important with a prepared agenda. Any hospital has constantly before it enough problems for a year's council program.

Dues should be just enough to cover cost of printing, postage and miscellaneous expense. It is assumed, also, that as the secretaryship rotates, the clerical work is furnished by the current secretary's hospital.

An important item in the program should be the quarterly luncheons. These should be held at some spot away from any hospital and should be paid for by the council. More time is allowed for this meeting than the others. It has been our experience in San Diego that a stimulating discussion has always followed a luncheon meeting.

The meeting should start on time and, most important, end on time. Members who arrive late are the losers. The prepared agenda should be well timed. The chairman must see that extraneous matter and social conversation are instantly ruled out of order.

MAILING OF MINUTES

Another effective tool in the mechanics of council operation is the mailing of minutes of the meeting to each member as soon as possible after the meeting is concluded. Items of new business are to be introduced briefly enough to describe exactly the nature of the problem. Then, except in cases of emergency, the matter is held over to the next meeting. This gives everyone a chance to study the proposal. Data and statistics may be prepared. The discussion the following month usually will settle the problem.

One final admonition: The "big hospital" complex should be avoided. A man whose background is such that he has been selected as a hospital administrator is also the type of individual, 99 times out of 100, who instantly appreciates the full value of cooperative effort. He can and will help others.

Lily of the Valley

Tulip

Bleeding Heart

—Photos by the author

Flowers under the x-ray—a new form of art

An experiment brought amazing results

SISTER MARY ALICE, S.C.

EIGHT YEARS AGO, a new form of art, the applying of x-ray techniques to the reproduction of flower images, was developed in the Good Samaritan Hospital, Cincinnati.

The resulting pictures, called "Flor de Rey" (flower of ray), are most decorative and have been distributed throughout the United States and Latin America. Two of the studies went to Europe.

The cut flowers must be fresh and are x-rayed with an old model open-tube x-ray machine to obtain the low voltage necessary to film the delicate flower. As the low voltage x-ray produces a nondescript grey background, the first flower images consequently lacked sharp definition and contrast. We continued our experiments until we discovered the secret of producing the rich black background such as high voltage x-ray creates, without destroying the delicate structural lines of the leaves and blossoms.

This is a form of art which reaches the very soul of beauty within the flower.

It all started out as a hobby, and after painting some of the black and white studies we used them in the decoration scheme of the x-ray department. This was the beginning of a real "business." Doctors, patients and visitors became interested and wished to purchase them. Reluctantly we sold our first experiments, and to date more than 500 studies have been marketed.

The pictures are made in three sizes, 8 x 10, 11 x 14 and 14 x 17 inches. The three sizes are furnished in black and white or tinted in natural colors, as taste and choice dictate. Prices range from $5 to $25 for unframed pictures; $10 to $50 for framed ones. Proceeds of the sales are used for hospital purposes. The process has been patented.

We see many possibilities for these unusual productions. The structural detail demonstrated by the x-ray could be made invaluable for botanical study. It is our ambition to compile a "Flor de Rey" picture manual for educational use.

Sister Mary Alice is x-ray technician at the Good Samaritan Hospital, Cincinnati.

For framing or for Christmas

Full-page reproductions of the unusual x-ray flower photographs shown at the top of this page appear on the following three pages of this issue of HOSPITALS. For those wishing copies to frame or to give as Christmas presents, HOSPITALS will make special reprints of the full-size pictures. These reproductions will be printed on heavy special paper, on one side only, trimmed to 9 x 12 inches.

The cost for reproductions of the set of three pictures will be $3, payable in currency or check with orders. All proceeds, above actual production costs, will be turned over to the Good Samaritan Hospital, Cincinnati, where the flower x-rays were originated. Orders should be addressed to Editorial Department, HOSPITALS, 18 E. Division Street, Chicago 10.

Through a combination of fifty dollars and practical ingenuity, this hospital produced an effective safety device.

A new "build-it-yourself" conductive shoe tester

CURTISS B. HICKCOX, M.D., AND BURTON B. LOVELL JR., SC.B.

SHOE conductivity tester at Hartford Hospital determines whether a person is sufficiently grounded for operating room safety.

TO MEET TODAY'S safety standards, an operating room must have, among other things, conductive flooring. But conductive flooring is of no value unless all equipment and all persons who work in the operating room are properly grounded to this floor. Conductive shoes are recognized as an important element in this grounding chain.

Before entering the operating room, however, how does one know that the conductivity of his shoes has not been lost because wax and dirt have accumulated on the soles to provide an insulating coating? How does he make sure that his hosiery will not interfere with the chain of conductivity?

We at Hartford (Conn.) Hospital have invested $50 and some labor in designing and building a simple device that gives us the answers to these questions in a moment. Resembling a modified bathroom scale more than anything else, it performs the important task of telling whether static electricity will be carried off to ground through a person's shoes.

This device, then, drops neatly into place as a vital safety measure to protect patient and personnel from the hazards of violent injury or death. It is part of a long story, dotted here and there by tragedy and marked with the signs of a long, uphill climb.

WHY IT GREW

Great as are the gains in medical practice through the use of anesthetics, these gains are not come by without proportionate problems.

By nature, most of the anesthetic gases used today are highly combustible. Their use demands the utmost in caution, since accidental "touching off" by whatever source may prove fatal.

Since, at present, combustible materials cannot be withdrawn from the operating room, prevention of ignition becomes the prime concern. The most difficult to control among possible sources of ignition is the chance spark of static electricity.

A definite aid in its control was made possible through adoption in 1941 by the National Fire Protection Association of the principle of grounding all personnel in hazardous locations. Grounding is accomplished primarily by the use of conductive flooring coupled with the use of conductive shoes by those who walk upon the floor. In addition, drag chains or conductive casters and tips are used to link all furniture and apparatus with the floor.

In the most recent revision of the "Recommended Safe Practices for Hospital Operating Rooms," shoes which are suitable for operating room personnel are described as follows:

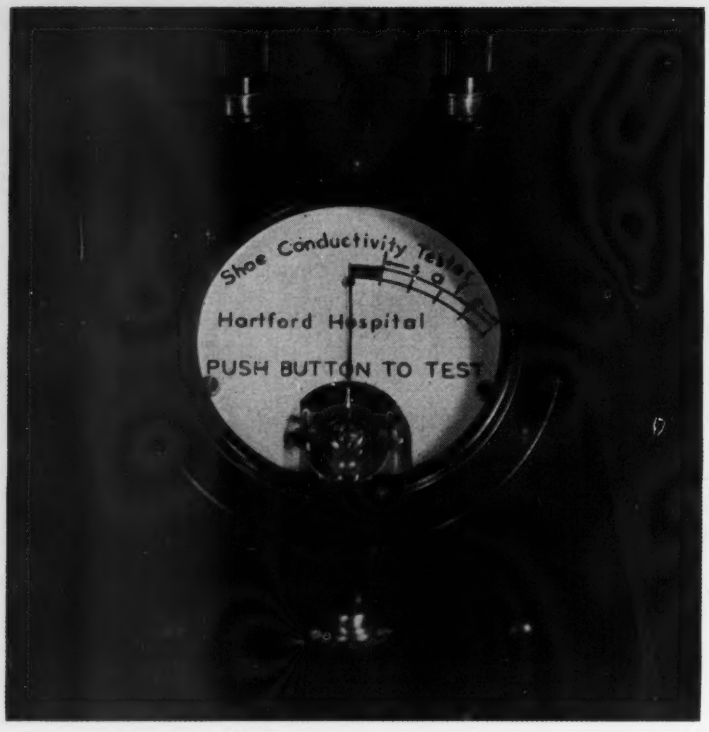
"Because of the possibility of percussion sparks, shoes having ferrous nails which may make contact with the floor should not be permitted in storage locations for combustible anesthetic agents or in anesthetizing locations.

"The recommended method for electrically connecting all persons entering anesthetizing locations to conductive floors is through the wearing of shoes conforming to the following specifications:

"All shoes having soles and heels of conductive rubber, conductive leather, or equivalent material, should be so fabricated that the resistance between a metal electrode placed inside the shoe and making contact with the inner sole, equivalent in pressure and area to normal contact with the foot, and a metal plate making contact with the bottom of the shoe, equivalent in pressure and area to normal contact with the floor, shall not be more than 250,000 ohms.

"Footwear or other personnel conductive devices to be introduced into hazardous locations *should be tested* on the wearer prior to each use in a hazardous location. Such test may be made by a direct reading ohmmeter, or simi-

Dr. Hickcox is associate anesthesiologist and Mr. Lovell is chief engineer, Hartford (Conn.) Hospital.



ORIGINAL meter scale in the galvanometer was removed and replaced by the one shown above. The dark area on the scale is in red.

lar approved instrument, indicating the resistance between two insulated electrodes so located that the wearer may stand in a normal manner with one foot on each electrode. The electrodes may be of some non-oxidizing metal such as stainless steel. Shoes in use for which the indicated resistance between electrodes is one megohm or less are considered safe."

HOW IT GREW

The recommendations above were used as a guide by our hospital engineers in designing our simple, inexpensive, but dependable shoe conductivity tester. Already, it has performed satisfactorily in our operating and delivery rooms.

Specifications state that each shoe should have a resistance not exceeding 250,000 ohms and that the combined resistance of two shoes and the wearer's body should not exceed one million ohms. The control of current must be such that a person will not receive a shock when standing on the footplates of the conductivity testing apparatus with bare wet feet.

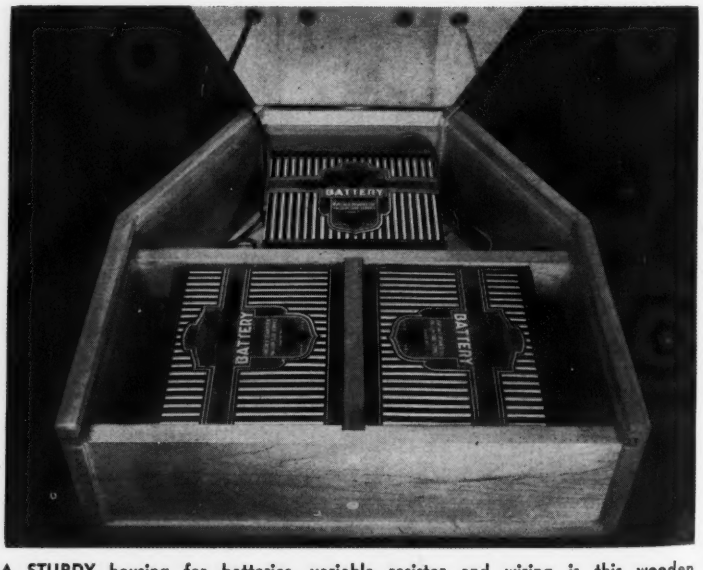
Since the minimum perceptible current is less than one milliampere (1/1000th of an ampere), the short circuit current should be held to one milliampere or less. A standard galvanometer, obtained for about $15, is sufficiently sensitive for use in the shoe tester. The full-scale current of this meter is one-half milliampere, which is well within the safety limit.

The galvanometer, as received, was equipped with three test buttons. Our engineers disconnected two of these buttons, leaving only the center one in operation. The meter scale was removed carefully and a special new scale was cemented to the back of the original before it was reinserted in the instrument.

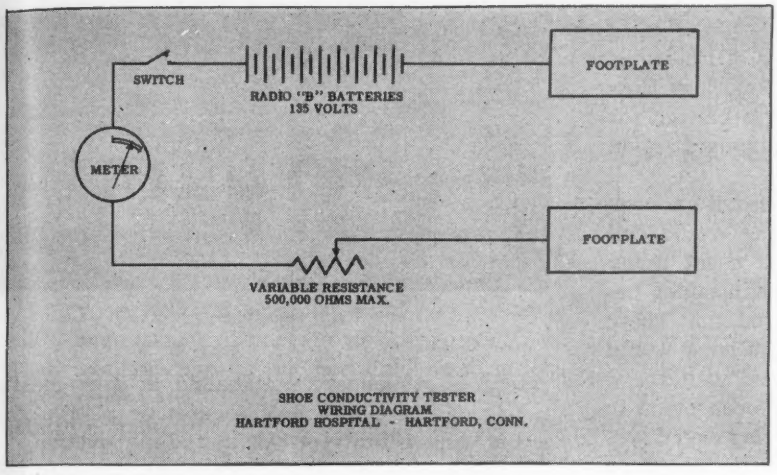
The left half of the new scale is blank and the right half is marked off into "safe" and "unsafe" ranges. The "unsafe" range, marked in red, extends from the center point of the scale (representing high resistances) to a point corresponding to one million ohms resistance. Comprising the balance of the scale to the right is the "safe" range, indicating resistances of less than one megohm.

The point on the scale corresponding to maximum allowable resistance for shoes and body was determined by inserting a known resistance of one million ohms across the metal footplates, and, with the full resistance of the variable 500,000 ohm resistor in circuit, noting the position of the needle on the scale. This was accepted as the dividing line between safe and unsafe ranges.

The power source consists of three 45-volt radio "B" batteries



A STURDY housing for batteries, variable resistor and wiring is this wooden box. The cover of the box may be removed for inspection by sliding it backwards.



connected in series to provide 135 volts. A 500,000 ohm variable resistor and a one million ohm fixed resistor completed the equipment purchased. All other necessary material was available in the hospital shops.

The galvanometer rests on a wooden pedestal that is supported by a 1½-inch metal pipe-stand, through which the connecting wires pass. The base of the unit consists of a substantially built wooden box (maple or birch preferred) in which are housed the batteries and the variable resistor. For access to the batteries, resistor and wiring, the cover of the box may be removed by sliding it backwards. On top of the cover, a sheet of bakelite is attached on which are fastened the two stainless steel footplates. The footplates are wired into the electrical circuit by extending a bolt from each plate through the bakelite and wood box top (carefully avoiding contact with the wood). The wiring was attached to the bolts on the underside. It is essential that all other bolts and nuts fastening the stainless steel footplates to the bakelite be kept from contact with the wood top by the countersunk holes.

It will be necessary periodically to test the equipment for accuracy as the batteries become discharged. This is done by placing the known one-million-ohm resistance across the footplates and adjusting the variable resistance until the meter needle rests again at the dividing line between safe and unsafe ranges of the scale.

The shoe tester described cost us about $50. It is easily transported, weighs about 75 pounds, stands four feet high and covers two square feet of floor space. It should be placed in a spot on the operating and delivery floors convenient to all personnel. To operate the tester an individual stands with one foot on each footplate and presses the single button immediately below the scale on the galvanometer. If the galvanometer needle deflects across the scale into the "safe" range, the shoes have a resistance of one megohm or less and are sufficiently conductive to electrically connect the individual to conductive flooring. If the needle does not move out of the red position of the scale, the footwear has a resistance greater than one megohm and is not safe.

If the scale shows the shoes to be unsafe, the wearer should clean the soles. This may be accomplished by scrubbing them vigorously back and forth on an ordinary fiber doormat contained in a shallow metal pan next to the testing apparatus. The mat should be kept moistened with water. After cleaning, a second test should be made.

In the event that the needle shows no deflection when the testing button is pressed, the apparatus may be checked quickly by connecting the two steel footplates with the fingers of one hand and depressing the test button. If the tester is in working order, the needle will deflect into the safe position of the scale. If there is no deflection, the apparatus is considered out of order.

ONE FOR THE RECORD

Rustles in the dark

IT WAS IN THE EARLY MORNING hours when a nurse aide, returning to duty after two nights off, paused at the doorway of the darkened women's ward of the Community Hospital, Kane, Pa. The only sound she heard was that of rustling paper. Disturbed about the source of this sound but not wishing to disturb any of the sleeping patients, she quietly tip-toed down the rows of beds until she found the one from which the sound emanated.

"Is there anything I can do?" she asked the patient in that bed.

"No, thank you," was the reply.

Still puzzled about the sound of rustling paper from this pitch black section of the ward, the aide continued, "I thought I heard paper rustling and perhaps you wanted something."

"No," repeated the woman in the darkness, "I could not sleep and so thought I would read for a while."

The nurse aide was now really alarmed, thinking that the patient was delirious and noting that none of the usual precautions for such a condition had been taken. She hastened to contact the floor supervisor with her story.

On hearing the aide's experience, the nurse hastened to reassure her, "Don't worry; the patient *is* reading. She is blind and is reading her braille newspaper which came today.—*Published in the Kane (Pa.) Republican and submitted by* HARRIS B. JONES, *administrator, Community Hospital, Kane, Pa.*

Any good anecdote is one for the record. Share yours by sending it to "One for the Record," editorial department of HOSPITALS, *18 E. Division Street, Chicago 10.*

EDITORIALS

Hospital Standardization

FOLLOWING APPROVAL by the House of Delegates in Atlantic City September 20, the American Hospital Association is now developing a pattern for the establishment of a hospital standardization program.

Since the proposal was first discussed, it has been recognized that such an undertaking would call for unselfish cooperation from the great many professional persons who serve the hospital patient. Further, it has been expected that these men and women, particularly physicians, would be concerned about their professional welfare.

With this in mind, an effort has been made to forestall unwarranted fears by offering every possible assurance in advance that no one would be asked to sacrifice any professional rights and privileges he now enjoys.

★ ★ ★

An editorial in the September 30 *Journal of the American Medical Association* states that the American Medical Association will not allow professional staffs of hospitals to fall under the complete control and domination of hospital trustees and administrators. An impression is created that the establishment of a standardization program by the American Hospital Association is a serious threat to the security of doctors and their national professional organizations. It erroneously assumes that the American Hospital Association is an organization of laymen who "seek to usurp the rights of professional groups to determine the best medical standards" and predicts that the welfare of patients would be jeopardized by further inroads on professional freedom.

These contentions merit further analysis by the American Hospital Association, American Medical Association and American College of Surgeons (which has indicated a willingness to transfer its 30-year-old standardization program to an acceptable agency) in terms of past and currently existing functional relationships.

It should be remembered that all three organizations have a common primary objective—the highest possible standard of medical and hospital care of patients. All three are professional organizations whose members sincerely believe that their organizations respectively and collectively have a mutual obligation to the public welfare.

★ ★ ★

Without physicians, there can be no hospitals. Without physicians, there can be no competent medical service. While it remains true that a large majority of conditions for which people consult their physicians can be cared for in the office, clinic or home, the hospital is the sole agency in which all resources for the care and proper treatment of serious illness are available. To provide these resources, which are marshalled at a moment's notice on the physician's request or instruction, is the responsibility of hospital administration.

The medical profession recognizes the need for and value of hospital services. It realizes that the well-organized and well-administered hospital makes it possible to render adequate and competent professional service. The best equipment and skilled personnel alone, however, do not guarantee a high quality of medical care. For this the physician, through the organized staff of the hospital, must be responsible.

The basic principles were enunciated years ago by medical and hospital organizations. They were promulgated by the American College of Surgeons in its standardization program. They govern both existing administrative and professional hospital-physician relationships. They are sound and fair to physicians, hospitals and patients, and they will continue to be so. In fact, there is strong evidence that continuation of the voluntary system of hospital and medical care in the future depends upon the joint cooperative efforts of hospital and medical organizations.

★ ★ ★

It has been established legally that hospital governing boards have the right and duty to adopt regulations aimed at improving the hospital's efficiency and its standards of service. Hospital governing boards are responsible morally, and under certain conditions legally, for the proper care of hospital patients as well as for the general conduct of administrative and professional staffs. While standards of practice should originate with the medical or professional departments, the limitations, control and execution must be in the hands of the hospital's governing board. Court decisions place such responsibility squarely on the governing board.

It is important to bear in mind that nothing should be permitted to interfere with the physician and the control of his professional service. No authority, hospital or other, can direct the physician's professional service to his patient. Hospitals do not, and should not, practice medicine. This must remain the prerogative of the physician.

Collectively, physicians can and should effectively police their profession and regulate the professional conduct of their members. They are responsible, through their organized efforts, for the maintenance of the highest quality of medical service that can be rendered the public. The governing board's long-established and long-recognized role in hospital standardization has been merely to make sure that the medical staff carries out this responsibility.

Likewise, hospital administration has responsibility for the same ultimate goals as do physicians. Their contribution is in hospital organization, management and the maintenance of high administrative standards. Friction in areas where hospital administration and professional standards overlap may be inevitable, but they are reconcilable.

The contribution to quality of medical care through support of good staff organization by hospital governing boards and administration has been significant. The American College of Surgeons program largely depended for success on such support in the complex medical-hospital relationships outlined here. In the light of past experience and existing circumstances, organized medicine has a great stake in continuing and increasing the participation of hospital administrators and governing boards in a standardization program under a plan which insures vesting of authority for medical standards in the medical profession.

Anniversary

THE NOVELTY has worn off, but the fact that TRUSTEE has just passed its third birthday probably is worth mentioning.

All through the summer of 1947 a journalistic pot boiled furiously at 18 E. Division Street. Never had there been a separate magazine for hospital governing boards, and every encouraging word was offset by a grave doubt.

Some persons wished the project well but honestly felt that hospital trustees would not take time to read what was to be published for them. Many asked: "What will there be to write about after the first few issues?" Convincing answers were not to be found, but faith was strong.

Near the end of its third year, TRUSTEE concluded a series on "The Board's Control of Hospital Medical Care" and offered this series in bound reprint form at a modest price. The first wave of orders exceeded 6,000, and this at a time when the regular subscription list was passing 16,000 for the first time.

Of course such statistics are not final proof of achievement. The purpose of TRUSTEE is to elevate the quality of hospital service through the education of governing board members. While a steady stream of correspondence from administrators and board members suggests that this purpose has been reasonably well served to date, such an assignment is never really finished.

Central Formula Service?

SEVERAL HOSPITALS in the San Francisco area have achieved the ultimate in streamlining their infant formula making procedure. They have farmed it out to a commercial laboratory, and an article in this issue of the journal reports the experiment a success.

Of course the hospitals did not contract for a commercial service without investigation, and special attention was given to two obvious hazards. One is the outside laboratory's inability, for any reason, to deliver formulas when and in the quantity needed. The other is the danger of cross-infection.

It was not difficult to reduce the perils of a failure in delivery. Should anything happen to the supplier's main plant, he has two other laboratories in other parts of the city. Should anything happen to all three plants, the hospital keeps handy "a kit that contains all the material necessary for the preparation of formulas by the pressure technique of terminal heating."

To guard against contamination, the commercial service has been patterned on "methods developed and recommended by the American Hospital Association's Committee on Procedures and Layout for the Infant Formula Room." Cleaning areas and formula preparation areas are separated. Recommended temperatures are maintained. Employees are examined periodically, and the surgery scrub is routine. Tests have shown the delivered formulas to meet all requirements. The laboratory is licensed and so subject to inspection by state health authorities.

In thus farming out their formula making routine, these hospitals appear to have taken all the precautions that can be taken, and they have wisely satisfied themselves that the commercial service is competent. Their experience so far does not necessarily prove, however, that such streamlining is a safe precedent for others to follow.

No service to hospital patients calls for more careful supervision than the handling of infant formulas, for no other service is more subject to serious accident. The terminal heating procedure has been pronounced safe when technique is not broken, but it is in no sense accident-proof.

Whatever the hazards in a single hospital, they would almost certainly be multiplied by the number of hospitals subscribing to a central service. It is extremely doubtful that authorities who have worked out the terminal heating procedure would look with approval on any trend in this direction.

A five-month demonstration project paved the way for admission x-rays in hospitals of less than 100 beds.

Routine chest x-rays in the smaller hospital

PAT N. GRONER

THE PURPOSE of conducting a five-month routine x-ray demonstration project at the 89-bed Barre (Vt.) City Hospital (November 9, 1949, to April 1, 1950) was not merely to prove its need or to sell the staff and board of directors. Instead, its aim was to help determine the best means by which a routine program could be established and operated on a permanent basis in small hospitals.

The screening value and even the diagnostic value of routine admission chest x-rays in hospitals have been proved time and again, even in areas where there exists a low incidence of tuberculosis. Just how to best apply the procedure to hospitals with fewer than 100 beds thus far has been an unsolved problem in Vermont and many other states.

Dr. Roscoe E. Avery, radiologist at the Barre City Hospital and superintendent of the Washington County Sanatorium, had been interested in routine admission x-rays of hospital patients for several years. During the early part of 1949 this matter was discussed between him and the author frequently. The executive director of the Vermont Tuberculosis Association was consulted in regard to the feasibility of such a project at the Barre City Hospital. He suggested that a study lasting for several months be conducted at the hospital to determine whether or not routine x-rays would be practical for small hospitals throughout the state. Permission was obtained from the tuberculosis division of the Vermont Department of Health to use its mass x-ray photo-fluorographic 70-millimeter unit, which previously had been used in community surveys throughout the state. The surveys were becoming increasingly expensive and showing diminishing results, and the department of health gladly lent the equipment for a period between its lightly scheduled community projects.

Because of the high tuberculosis incidence and death rate in the area, the tuberculosis association felt that Barre would be an ideal place to set up the first hospital x-ray experiment in the state. In 1949 there were 35 deaths from tuberculosis in Washington County, population 41,000, in the center of which lies Barre, the largest granite center in the world.

CAUSE OF HIGH DEATH RATE

The high rate is principally attributed to the great number of stone cutters who process and carve the granite blocks once they have been quarried, thus making tuberculosis, an almost inevitable outgrowth of silicosis, an occupational disease. Although dust-control equipment has been installed in recent years, a great number of old-time workers and foreign-born has caused the rate to remain high.

The unit was installed in a small room adjacent to the ambulance entrance in November 1949. The tuberculosis association assumed the expense of converting the equipment from roll film to a cut-film adapter for individual exposures. Association personnel also indoctrinated the hospital technician in the operation of the unit.

From the outset it was anticipated that the four chief stumbling blocks for operation of any small hospital routine x-ray service would be (1) location of the equipment, (2) over-all responsibility for operation, (3) thorough indoctrination of all persons connected with the service, and (4) complete medical follow-up. Methods of overcoming most of these difficulties were worked out before the demonstration was concluded.

During the particular time that the equipment was in operation at Barre, the physical plant proved to be a handicap to the program. Remodeling plans and a new wing were only partially completed. The infrequently-used main entrance and the administration and admitting offices of the hospital were on a different floor and at the opposite side of the building from the temporary chest x-ray set-up.

Most admissions entered the hospital through the ambulance entrance because it was more easily accessible from the parking area. There were no admitting office facilities at this entrance, however, and it was not possible to hold up these admissions for their x-rays because they had to go directly to the floors where the admission information was obtained. As a result a considerable number of patients missed being x-rayed upon admittance. There also was considerable loss of time, as it necessitated added efforts to be certain that the patients were returned for their chest x-rays as soon as possible.

It is of utmost importance to obtain the x-ray directly upon admission so that, if necessary, the precautionary technique can be applied early and followed thoroughly during the patient's stay. Too many other contingencies can arise, once the patient gets settled in his room, to guarantee that he will have the routine chest picture taken at all, whether his stay is a short one or a long one.

Responsibility for x-raying patients was placed upon the one x-ray technician regularly employed

Mr. Groner is administrator of the Barre (Vt.) City Hospital.

by the hospital for all x-ray work. She checked daily with the admitting office and each floor to learn the status of the patients. This worked well for several weeks when, by coincidence, there were comparatively few discharges over the weekends.

In December, however, a substantial increase in the number of patients being discharged over the weekends, without routine chest x-rays, was experienced. These would be admitted during the week, generally for surgery, and would not be ambulatory until the weekend, at which time they would be discharged.

NURSES OPERATE MACHINE

To correct this, two or three nurses on each floor were instructed in the operation of the photo-fluorographic unit. The head nurse or supervisor of each floor was responsible for seeing that each patient on her floor was x-rayed. This action eliminated the problem but resulted in a great number of double exposures because of the nurses' inexperience in operating the machine. This is a factor difficult to control if the unit is operated by more than one person or by personnel in different departments.

The necessity of thorough indoctrination is obvious. This means not only the persons actually involved in the operation of the unit and processing of the film but the medical staff and those participating in the follow-up as well.

Although the project had been discussed at staff meetings, developments indicated that the subject was not adequately covered. Our radiologist gave findings in each case, and these became a part of the patient's medical chart. In some cases the doctors accepted the findings as conclusive and did not order a 14 x 17-inch plate when such was indicated. As a result of this and our inability always to obtain an x-ray at the time of admission, there were several incidents, during the first two months, of the discharge of patients whose findings had indicated further study. This was corrected by having a 14 x 17-inch plate taken in *all* questionable cases unless the attending physician, with his previous knowledge of the case, gave specific orders to the contrary.

The program also focused attention on the hospital's precaution technique of suspected cases. In an effort to have as effective a precaution as possible, a committee consisting of the radiologist and one of the staff members, the director of nurses, the director of the school of nursing, and the administrator adopted a new routine. In addition to the ordinary techniques, this routine consisted of placing ultraviolet lamps and glycol vaporizers in the patient's room and using paper dishes and utensils, which were placed in paper bags and burned after use. Neither student nor graduate nurses are permitted to participate in the care of suspected patients unless they have a positive patch test.

Follow-up on all positive findings consisted of notifying the attending physician and taking a 14 x 17-inch film if the patient was still in the hospital. In cases where the patient was discharged prior to processing of the film, the doctor was notified, as was the tuberculosis division of the department of health.

At the conclusion of the project, each doctor was asked to submit a report concerning the follow-up of all his patients x-rayed during the five-month period. This report revealed that only toward the end of the experiment were the physicians seriously making every effort to follow-up the radiologist's recommendations. At such time when a permanent routine admission chest x-ray plan is in operation, this will become standard procedure.

One weakness discovered during the study, touched upon earlier, was that a responsibility was not placed upon one person or department. Under a permanent plan the admitting office would be responsible for x-raying all patients at the time of admission (possibly prior to admission for maternity patients). Patients admitted during the hours when the admitting office is closed will be followed up by the admitting office personnel.

FINANCING

In most small hospitals the cost of financing a routine admission x-ray system will be the most deterring of all factors. Our radiology department processes approximately 225 diagnostic x-rays per month. Along with her regular daily duties the x-ray technician generally had sufficient time to devote to the routine admission work. The radiologist volunteered his services and would continue to do so under a permanent plan. The costs of supplies for the photo-fluorographic units is quite low, being only a few cents per film. Therefore, operating expenses in our case were manageable, but the situation may be entirely different in a hospital where the work load is greater.

There is no question but what automatic equipment is too expensive for most hospitals with fewer than 3,000 yearly admissions.

It is possible to obtain rebuilt units of recent manufacture selling for a fraction of the original price. Our plan is to purchase a rebuilt 35-millimeter photo-fluorograph for approximately $1,500, which can be used in conjunction with our portable x-ray machine, thereby eliminating the expense of a generator. To extend cables and purchase cassettes, film viewers and processing hangers would add another $150 to the expense.

The cost of the program, if conducted with existing 14 x 17-inch equipment, would have to be borne

Routine chest x-ray results

Total admissions, excluding births:		1,101
Patients x-rayed:		646
Negative:	517	
Tuberculosis: (Previously known: 10)	22	
Heart, aorta, heart & aorta, atypical pneumonia, mediastinal pathology, etc.:	55	
Double exposures, exposed to light, etc.:	52	
	646	
Patients not x-rayed:		455
Children:	209	
Deaths:	29	
14 x 17 x-rays:*	87	
Nonambulatory patients and missed films:	130	
	455	

*Because most of the routine x-rays were taken late during the patient's hospitalization, these 87 had already received 14 x 17 plates, and the small plates were unnecessary.

by an extra fee were the Barre City Hospital to try routine x-rays without special equipment. With miniature films, it should be possible to absorb this work in the normal hospital budget. Institutions smaller than ours probably would do better to consider conducting the program by adapting present equipment insofar as possible. The larger institutions might find it more practical to install automatic equipment.

A special committee, composed of physicians on the board of the tuberculosis association, has been giving its attention to hospital x-raying in Vermont and has followed the Barre results closely in order to help other hospitals introduce programs of their own. Other demonstrations are planned, and efforts may be made to secure financial aid from the state to get the routine program started throughout Vermont. This can be done, however, only after each hospital decides upon the method it can best employ.

The Barre City Hospital demonstration, while not outstandingly productive as a case-finding program, was especially successful in paving the way for future operation of routine plans, both at Barre and elsewhere in the state.

AFTER FIVE MONTHS

The following conclusions were drawn from the five-month experiment:

1. The hospital board, administration, nursing staff and, above all, the medical staff must be *completely* oriented and "sold" on the program.

2. The physical location of the unit should be as close as possible to the admissions desk, and all entering patients should be x-rayed at once.

3. One person should have full charge of the program; not more than three persons should be instructed in taking the pictures, and 24-hour service should be available.

4. The floor supervisor should make certain that all patients on her floor who are physically able have been x-rayed upon admission or are x-rayed as soon as possible.

5. The radiologist should promptly record the findings, either satisfactory or unsatisfactory, on the patient's record chart.

6. Each attending physician should make every effort to follow up each unsatisfactory finding, even if the patient has already left the hospital.

7. Provision should be made to set up protective measures in the event that tuberculosis in a patient is discovered or suspected.

8. The routine program should include all admissions—even maternity patients and outpatients where possible — except children under 12, the newborn and the stretcher cases.

9. The films should be taken, developed and read all within the same day in order that immediate follow-up may be started if necessary.

10. A statistical record of the program should be carefully kept in order to find weaknesses or flaws that might be corrected.

FOR STUDENT NURSES

Recruitment—small hospital style

OUR HOSPITAL IS AN 18-bed institution in a small community. Knowing the need for student nurse recruitment and having a desire to do our share, we contacted the superintendent of the local high school and planned to get together with the students who were interested in nursing.

We held two 45-minute meetings with these students and then arranged a tour of the hospital in which the various phases of each department were explained. This was followed by a round table discussion held with our nursing staff.

Through continued cooperation with the school, arrangements were made for the students to spend one or two hours each day in the hospital. School credit was given for this time.

Our first teaching of these students was a thorough briefing on ethics, followed by a more practical "The Proper Way to Give a Complete Bed Bath." After a few weeks the girls were taught T.P.R.'s and other minor routine work.

Through the cooperation of the medical staff, the students are occasionally permitted to watch major surgery.

At the close of last year's school term, some of these students were planning their studies in junior college in preparation for nurses' training. Two of the girls remained with us as top-paid aides, fulltime duty. We definitely do not encourage the girls to remain with us though. Our primary purpose is to interest them in nurses' training.

Almost none of the students dismissed our program from their curricula, once they had begun. Some of the girls gave as much as 15 hours of voluntary work a week to the hospital, even though the school required only 45 to 90 minutes a day.

As can be imagined, this has been an enormous help to the hospital by relieving our registered nurses and trained aides from a great deal of routine work.

We hope to continue this work indefinitely, not primarily to help our staff, but to interest more girls in nursing.

It is a great morale booster to our nursing staff, since it gives them the satisfaction of knowing that they are contributing to the nurse recruitment program.—CLOICE M. BARRETT, *superintendent, Hazel Hawkins Memorial Hospital, Hollister, Calif.*

A NEW YORK HOSPITAL EXPERIMENTS WITH

Group practice in anesthesia

MAXWELL S. FRANK, M.D., F.A.C.H.A., AND S. G. HERSHEY, M.D.

TODAY THE anesthesiologist contributes much more to the care of patients than the mere production of insensibility.

He is a competent consultant who carefully evaluates the patient's history and physical status in selecting the anesthetic management for each individual. Such anesthetic management begins in the preoperative period, extends through the actual surgery in the utilization of a broad array of anesthetic agents and techniques, and continues postoperatively, in the recovery rooms and wards, until discharge of the patient. The anesthesiologist is versatile in the clinical application of many therapeutic resources ordinarily not exploited by other specialists. By virtue of his special knowledge the anesthesiologist has become a full member of the team striving for the best care of the surgical patient.

The current status of the anesthesiologist, however, varies considerably in different parts of the country. Regrettably, it must be acknowledged that in many hospitals patients are not receiving anesthetic care of a caliber comparable to that available in other medical specialties. The number of qualified practitioners in anesthesiology is insufficient to meet current needs, and it is obvious that more medical practitioners must be attracted to the specialty, particularly in view of the probable increasing future need for them.

It is not the purpose of this discussion to enter into controversial medical and administrative aspects of anesthesiology, but simply to present what we consider a workable solution to the problem.

The nature of this specialty requires that its locus be within the hospital proper, as contrasted to an office or clinic practice. Thus the anesthesiologist should be a member of the professional staff.

Undoubtedly, some hospitals fall short of assuring physician-anesthesiologists attractive professional careers by failing to accept them on the same basis as any other well-trained, competent specialist. The charge of exploitation is a deplorable one, but it has been attributed with some frequency in recent years to both practitioners and hospital officials. Only recently, the house of delegates of the American Medical Association went on record stating that the practice of anesthesiology is the practice of medicine, with the implication that hospitals should not discourage or prevent private practice by the anesthesiologist.

On the other hand, it is contended with equal validity that to regard this service as part of hospital care in no way diminishes its stature or dignity as a medical service, and that equitable relationships are best accomplished by negotiation on the part of those directly involved in the individual hospital.

BETH ISRAEL'S PROGRAM

In New York City's Beth Israel Hospital, a highly specialized voluntary urban institution with a university affiliation, it was decided to develop a truly academic department of anesthesiology and to realize a well-rounded program of teaching and investigation that would be comparable with other hospital departments.

The hospital took the responsi-

Dr. Frank is executive director and Dr. Hershey is attending anesthesiologist, Beth Israel Hospital, New York City.

bility of encouraging physicians to enter this specialty by putting them on the same professional basis as other specialists and by establishing a sound training program completely acceptable to the certifying board.

The emergence of anesthesiology into a formal definitive professional status cannot but work to the benefit of the patient, the hospital and the community. In accepting its responsibilities, the hospital, through its medical staff, reached agreement on several fundamental principles, whose practical application has produced the organization which we now find satisfactory from virtually every point of view.

GUIDING PRINCIPLES

These principles guided the development of the anesthesiology department:

1. The well-trained medical anesthesiologist can make a real contribution toward improved medical and surgical care. This principle is predicated on the belief that, just as the obstetrician has replaced the midwife, so the physician-anesthesiologist should eventually supplant the medical technician if the best interests of the surgical patient are to be served.

2. The medical needs of patients are certain to be better met where students are being taught. A good anesthesiology service is much more likely to be developed and maintained in an institution offering accredited training in the specialty.

3. The intrinsic nature of the specialty permits its practitioners to serve patients and the hospital best when the physicians function as a team. It must be emphasized, however, that this type of group practice within the hospital organization does not alter the status of the individual physicians. They must be regarded as members of the staff in the same manner as other specialists, enjoying the same privileges and responsibilities according to their ability and rank. For example, at this hospital the attending anesthesiologist holds full membership on the medical board by virtue of his position on the staff.

4. Already mentioned is the economic relationship, which must be clarified on an individual basis, between the hospital and the anesthetist. In this institution, complete agreement was reached on the principle that the hospital would not utilize the services of the anesthesiologist to provide budgetary income, nor would the anesthesiologist, as a medical practitioner, be subsidized or become a budgetary liability.

On the basis of the foregoing cardinal principles, the hospital has organized and developed an anesthesiology service resulting in fundamental improvements in the care of patients. The details of organization, if adopted by others, will necessarily vary in different localities and institutions and should be kept sufficiently flexible to adjust to the progress of medicine.

STAFF ORGANIZATION

The staff consists of five physicians—an attending, an associate, and three adjuncts—appointed to the medical staff of the hospital by the board of trustees on the same basis as the physicians on any other service. Although they are private practitioners, serving as a group, these anesthesiologists are considered fulltime staff members in that their outside professional activities do not include private practice at any other hospital. Within this hospital, these physicians function as members of a typical medical group, professionally and financially, with the attending anesthesiologist as head. All members of the staff are diplomates of the American Board of Anesthesiology.

There are three residents in anesthesiology, each appointed for a period of two years' training. The residency is approved by the American Medical Association and the American Board of Anesthesiology.

The residents receive a carefully integrated training program with graded responsibility covering all phases of anesthesiology. They administer anesthesia to ward patients under staff supervision and assist the staff members in the anesthetic care of most private patients.

In the light of the formidable surgical procedures now commonly undertaken, the attitude that anesthesia is a one-man job is outdated. A second pair of trained hands is frequently as necessary to the man at the head of the table as it is to the operating surgeon. With an average of somewhat more than 5,000 operations of all types during the year, the opportunities for professional education available to the residents are very extensive.

FACILITIES AND EQUIPMENT

The anesthesiology service has its own well-equipped office on the operating floor and the service of a fulltime secretary. Office facilities and secretarial assistance have proved indispensable to the department in the maintenance and full utilization of good records, equipment and drug inventory control, liaison with the various administrative departments, and a smoothly functioning and efficient clinical, investigative and teaching organization.

Adjacent to the departmental office is a small examination room which is used for both therapeutic and diagnostic nerve-block procedures in ambulatory patients and for the storage of records and equipment.

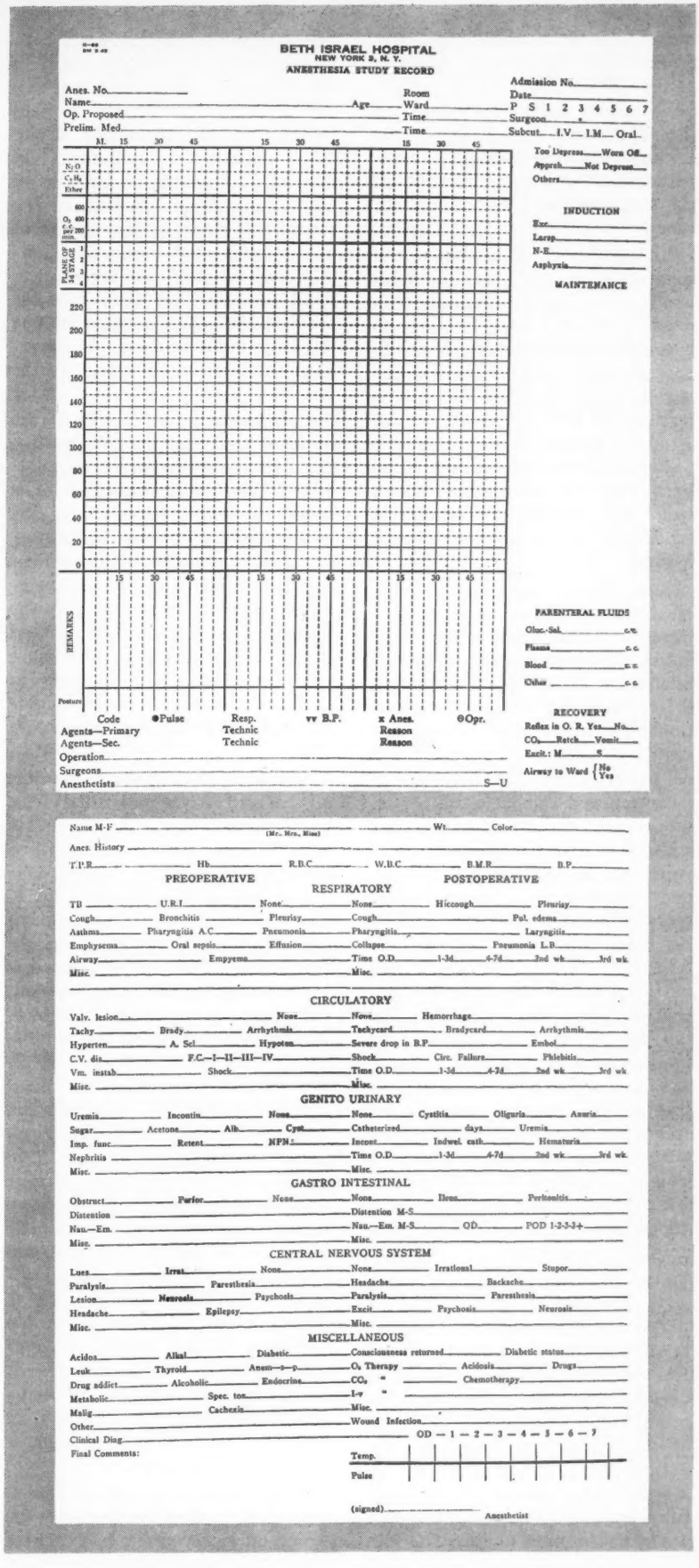
We have found it wise to equip the service with an almost lavish supply of modern, perfectly functioning anesthetic apparatus, with a safe reserve of expendable items. Because it is a teaching service, there is kept on hand a complete variety of currently used equipment and anesthetic aids. This attitude toward equipment has not proved extravagant. On the contrary, careful handling has made repairs and replacement infrequent, with resulting economy of operation. In addition, the comfort of having enough of whatever equipment is best suited for any type of technique cannot be overemphasized. When considered in terms of other hospital expenditures for comparable equipment, the cost of good and sufficient anesthesia apparatus is actually quite reasonable.

CLINICAL PRACTICES

Every effort is made to keep clinical practices consistent with

AT EACH surgery patient's first visit a detailed "Anesthesia Study Record" is begun. This record is carefully kept during the operative procedure and is continued throughout the patient's hospital stay by means of frequent postoperative visits.

the highest standards. Every patient is visited by the anesthesiologist before operation. At that time, the clinical chart is reviewed carefully and preoperative medication is prescribed. The anesthetic agent and technique are selected routinely by the anesthesiologist, although consultation with the surgeons is an invariable procedure, as is discussion with the family physicians, internists and the patients themselves. At this hospital the opinion of the anesthesiologist is respected and usually prevails. At the first visit a detailed "Anesthesia Study Record" is started for each patient. This record is carefully kept during the operative procedure and is continued throughout the patient's hospital stay by means of frequent postoperative visits. After surgery is completed, the anesthesiologist is routinely consulted and actually treats his patients within the sphere of his special province. This includes problems in pain relief, tracheo-bronchial toilet, oxygen, and fluid therapy. The services of one or all of the staff anesthesiologists are available at all times on special problems. The "Anesthesia Study Record" of each patient is catalogued, coded, cross-indexed, and filed to be immediately available.



BETH ISRAEL HOSPITAL
NEW YORK 3, N. Y.
ANESTHESIA STUDY RECORD

Anes. No. ____ Room ____ Admission No. ____
Name ____ Age ____ Ward ____ Date ____
Op. Proposed ____ Time ____ P S 1 2 3 4 5 6 7
Prelim. Med. ____ Time ____ Surgeon ____
Subcut. ____ I.V. ____ I.M. ____ Oral ____

M. 15 30 45 15 30 45 15 30 45

N_2O
C_2H_2
Ether
O_2 c.c. per min.
PLANE OF 1st STAGE 1 2 3 4
220 200 180 160 140 120 100 80 60 40 20 0

Too Depress. ____ Worn Off ____
Approh. ____ Not Depress. ____
Others ____

INDUCTION
Eac. ____
Laryn. ____
N-E ____
Asphyxia ____

MAINTENANCE

PARENTERAL FLUIDS
Gluc.-Sal. ____ c.c.
Plasma ____ c.c.
Blood ____ c.c.
Other ____ c.c.

RECOVERY
Reflex in O. R. Yes ____ No ____
CO_2 ____ Retch ____ Vomit ____
Excit.: M ____ S ____
Airway to Ward { No / Yes

REMARKS
Posture

15 30 45 15 30 45 15 30 45

Code ● Pulse Resp. vv B.P. x Anes. ⊖ Opr.
Agents—Primary Technic Reason
Agents—Sec. Technic Reason
Operation ____
Surgeons ____
Anesthetists ____ S—U

Name M-F ____ (Mr., Mrs., Miss) ____ Wt. ____ Color ____
Anes. History ____
T.P.R. ____ Hb. ____ R.B.C. ____ W.B.C. ____ B.M.R. ____ B.P. ____

PREOPERATIVE	POSTOPERATIVE
RESPIRATORY	
TB ____ U.R.I. ____	None ____ None ____ Hiccough ____ Pleurisy ____
Cough ____ Bronchitis ____	Pleurisy ____ Cough ____ Pul. edema ____
Asthma ____ Pharyngitis A.C. ____	Pneumonia ____ Pharyngitis ____ Laryngitis ____
Emphysema ____ Oral sepsis ____	Effusion ____ Collapse ____ Pneumonia L.B. ____
Airway ____ Empyema ____	Time O.D. ____ 1-3d. ____ 4-7d. ____ 2nd wk. ____ 3rd wk. ____
Misc. ____	Misc. ____
CIRCULATORY	
Valv. lesion ____	None ____ None ____ Hemorrhage ____
Tachy. ____ Brady. ____ Arrhythmia ____	Tachycard. ____ Bradycard. ____ Arrhythmia ____
Hyperten. ____ A. Scl. ____	Hypoten. ____ Severe drop in B.P. ____ Embol. ____
C.V. dis. ____ F.C.—I—II—III—IV ____	Shock ____ Circ. Failure ____ Phlebitis ____
Vm. instab. ____ Shock ____	Time O.D. ____ 1-3d. ____ 4-7d. ____ 2nd wk. ____ 3rd wk. ____
Misc. ____	Misc. ____
GENITO URINARY	
Uremia ____ Incontin. ____	None ____ None ____ Cystitis ____ Oliguria ____ Anuria ____
Sugar ____ Acetone ____ Alb. ____	Cyst. ____ Catheterized ____ days ____ Uremia ____
Imp. func. ____ Retent. ____	NPN: ____ Incont. ____ Indwel. cath. ____ Hematuria ____
Nephritis ____	Time O.D. ____ 1-3d. ____ 4-7d. ____ 2nd wk. ____ 3rd wk. ____
Misc. ____	Misc. ____
GASTRO INTESTINAL	
Obstruct. ____ Perfor. ____	None ____ None ____ Ileus ____ Peritonitis ____
Distention ____	Distention M-S ____
Nau.—Em. ____	Nau.—Em. M-S ____ OD ____ POD 1-2-3-3+ ____
Misc. ____	Misc. ____
CENTRAL NERVOUS SYSTEM	
Lues ____ Irrat. ____	None ____ None ____ Irrational ____ Stupor ____
Paralysis ____ Paresthesia ____	Headache ____ Backache ____
Lesion ____ Neurosis ____	Psychosis ____ Paralysis ____ Paresthesia ____
Headache ____ Epilepsy ____	Excit. ____ Psychosis ____ Neurosis ____
Misc. ____	Misc. ____
MISCELLANEOUS	
Acidos ____ Alkal. ____ Diabetic ____	Conciousness returned ____ Diabetic status ____
Leuk. ____ Thyroid ____ Anem—s—p ____	O_2 Therapy ____ Acidosis ____ Drugs ____
Drug addict ____ Alcoholic ____ Endocrine ____	CO_2 " ____ Chemotherapy ____
Metabolic ____ Spec. ton. ____	I-v " ____
Malig. ____ Cachexia ____	Misc. ____
Other ____	Wound Infection ____
Clinical Diag. ____	OD — 1 — 2 — 3 — 4 — 5 — 6 — 7
Final Comments:	Temp.
	Pulse

(signed) ____ Anesthetist

RESPONSIBILITIES

The anesthesiology group is responsible for the administration of every anesthetic, both to private and ward patients. Private patients are usually treated by a staff member with the assistance of a resident, while ward patients are cared for by a resident under the direct supervision of a staff anesthesiologist. In the interest of efficient coverage, the medical board has allocated to the attending anesthesiologist the prerogative of assigning his staff to scheduled surgical cases in accordance with his best judgment as to the requirements for each patient.

Although the surgeons possess

the privilege of requesting any specific anesthesiologist for any patient, this privilege, in effect, has virtually fallen into disuse, for the surgeons almost invariably acknowledge the complete competence of whatever member of the staff may be assigned to their cases.

An additional advantage to the surgeon is that he loses no time waiting for any one anesthesiologist to finish a case in order to become available to his patient. In emergencies, particularly after regular operating hours, there is no hunt for an anesthesiologist, for a staff member whose name is posted is always available. Administratively, this eases the difficult task of maintaining operating schedules in a smooth-running manner.

This type of coverage is successful only because of the group-practice arrangement. The individual anesthesiologist's income is unaffected either by the number or the financial status of the patients he treats. The sickest patients, regardless of whether free or paying, ward, semiprivate or private, are assigned to the senior, more experienced members of the staff. Furthermore, the volume of work can be fairly apportioned, and the time the anesthesiologist spends treating patients, training residents, doing investigation, attending medical meetings, and participating in organizational activities does not decrease his income. In fact, these non-income-producing activities are encouraged. An added benefit enjoyed by the members of the group is the fact that income does not cease with illness or vacation periods. This is actually a fulltime system, with the anesthesiologist's income dependent on the volume of work done by the hospital.

SCHEDULE OF FEES

The anesthesiologist receives no salary or income of any nature from the hospital. His income is derived solely from fees paid by private and semiprivate patients, all of whom are billed by the anesthesiologist through the group. These fees are pooled in a common fund and divided among the staff at the end of each month. The fees are charged to the patient's hospital account and are included in the hospital's bill to the patient. The business office remits the paid fees to the anesthesiology group in a lump-sum settlement at monthly intervals, accompanied by a supporting schedule of the individual patients and the fees paid. Uncollected fees are excluded from the monthly remittances until payment has been received from the patient, thereby precluding any involuntary or unscheduled subsidy to the group by the hospital.

It is the accepted policy of the medical staff and the administration that fees for the anesthesiology service be maintained at a moderate level, based upon the patient's ability to pay. In general, the fees for anesthesiology services are based on the rate of the specific accommodation occupied by the patient. This policy has resulted in fees which are generally more moderate than those charged in this community by anesthesiologists of comparable standing and ability.

The gross income of the service, all derived from individual fees, is allocated in the following manner: Ten per cent is paid to the hospital, an amount which was determined, on the basis of experience and careful accounting, to cover adequately approximately 60 per cent of the cost of maintaining the anesthesiology department, including telephone, secretary, stationery, postage, office equipment and housekeeping service. The basis of 60 per cent was fixed by the fact that this is the relative proportion of private to ward patients treated by the service. Two per cent of the remaining income is deposited in an "Anesthesiology Fund," which provides for the purchase of books, reprints and journals, and some special equipment. This fund also is used to defray expenses incurred by the residents in the course of their attendance at meetings, and for travel and hotel expenses of members of the staff when attending medical meetings as participants in an official program.

The remainder of the income is allocated to the members of the group on a percentage basis. These percentages are determined annually by mutual agreement and are based on rank, experience, and period of service. This financial arrangement is a matter of written record and is subject to the approval of the director of the hospital.

It is noteworthy that their incomes are considered satisfactory by the staff of anesthesiologists. In effect, they are earning their livelihood in what is essentially private practice and are enabled to practice their specialty under equitable and favorable circumstances. Insofar as the hospital is concerned, the anesthesiology service neither yields it any sizable income nor constitutes a budgetary liability.

OTHER FUNCTIONS

Oxygen therapy is under the direction of the anesthesiology service, and one member of the staff is assigned permanently to direct and supervise the activities of the oxygen-therapy technicians, as well as to act as consultant in inhalation therapy for any member of the medical staff.

The anesthesiology staff conducts a therapeutic and diagnostic nerve block service on a consultation basis for private and ward patients. Activities of this type completely justify the current enthusiasm at the hospital for the added care the department affords for patients.

As an established department, the staff holds regular meetings, is responsible for its share in the training program for nurses and house staff, and undertakes investigations. Individually, its members join in the medical and administrative functions expected of members of the medical staff.

For obvious reasons the foregoing outline of an anesthesiology service lacks the myriad of significant details that could enter into a more complete presentation. The factors of importance, however, have been mentioned and can be translated into a working plan for any similar institution.

At this hospital the results have been gratifying in that they have largely eliminated the shortcomings and inefficiencies of solo practice in anesthesiology.

Manual on women's auxiliaries gives organization process

MANUAL ON ORGANIZATION OF WOMEN'S HOSPITAL AUXILIARIES, with Model Constitution and By-Laws. Prepared by the Committee on Women's Hospital Auxiliaries of the American Hospital Association. Chicago, The American Hospital Association. 1950. 15 pp. $1.50

SINCE THE incorporation of the individual hospital auxiliaries into the structure of the American Hospital Association as Type V members, the national committee has been at work preparing material of help to these auxiliaries. The first publication, excepting the *Auxiliary Newsletter*, is the manual on organization with model constitution and by-laws, which was recently sent to all Type V members.

The manual may be purchased by member hospitals and would be of particular assistance in hospitals that are forming auxiliaries or in which existing auxiliaries wish to review their present organization and constitution.

Under the chairmanship of Mrs. Amos F. Dixon, and with the special efforts of Mrs. A. E. Pinanski, one of its members, the national committee believes that it has drawn up a recommended chart of organization, plus a model constitution and by-laws, that will enable an auxiliary to function in the most effective way. The hospital auxiliary does not need to adopt the manual word for word in order to qualify for Type V membership in the American Hospital Association. The suggestions offered, however, can be applied to local situations with good results.

The manual stresses the importance of clearly defining the purpose of the auxiliary and adhering to that purpose. In the organization of the auxiliary, the advantages of a rotating board are outlined. In cases where a board has had long tenure, the manual can be of assistance in establishing an authority and basis for change.—H.V.P.

Films available to hospitals

Following is the conclusion of the list, begun last month, giving information about films of value to hospital administrators.

Routine Admission Chest X-ray in General Hospitals

(16mm, black and white, sound, 21 min.)

Produced by U. S. Public Health Service, 1946.

On loan from local or state health departments. Also, the American Hospital Association Library has one print for loan; $4 for 3 days.

Purchase prints: Associated Screen News, Ltd., Benograph Division, 1330 Sherbrooke St., W., Montreal, Quebec. $33.

How photofluorographic equipment can be installed in the admissions offices of general hospitals so that all incoming patients can be given chest x-rays as part of regular admission procedure. Operation of the equipment, method of keeping patient's records, and how the system results in finding a significant percentage of otherwise undetected cases of tuberculosis. Promotes routine chest x-rays in hospitals.

Hospital Food Service Personnel Training

(16mm, black and white, sound, 17 min.)

Produced by U.S. Army, 1949.

Obtainable on loan from army surgeon of the army area where request originates.

Covers duties and activities of the various types of personnel in food preparation and the cleaning and washing processes. The continuity is based on preparation of a sample meal, and many hints for health safety are included.

Training film for food handlers; also shows importance of tasty food attractively served.

Malnutrition in the Hospital Patient

(16mm, color, sound, 30 min.)

Produced by E. R. Squibb & Sons, 745 Fifth Avenue, New York City 22, 1949.

Loan: E. R. Squibb & Sons, 745 Fifth Avenue, New York City 22.

In this film, malnutrition in the sick and the means of preventing it are discussed in detail by Dr. DuBois, Dr. Elman and Dr. Pollack.

The film opens with the case history of a healthy surgical patient who is fed an unsupplemented standard hospital diet. His daily progress is shown, with charts demonstrating how he is steadily using up his reserve of body protein, due not only to inadequate dietary protein but also to failure to eat. His loss of stored protein is superimposed on the loss of plasma proteins during surgery. He is becoming depleted, too, in the critical water-soluble vitamins—niacin, thiamine, riboflavin, ascorbic acid.

The film turns to a discussion of the newer principles of nutrition by Dr. DuBois, Dr. Elman and Dr. Pollack. Dr. Pollack recalls how trauma, surgery and infectious and wasting illnesses produce negative nitrogen balance. Dr. DuBois relates how these conditions are accompanied by "toxic destruction of protein"—a story first told by him decades ago. Dr. Pollack then discusses the need to prevent or minimize the usual protein starvation in convalescent patients. On the old-style nutritional regimen, much of the weakness attributed to surgery, injury or illness is actually due to malnutrition. Protein deficiency leads in importance, but vitamins are also needed. "The whole concept of adequate nutrition," says Dr. Pollack, "involves a proper ratio between all the various nutrients and foodstuffs."

Dr. Elman speaks about the problem of protein loss in injuries and surgery through exudates, discharges and loss of blood. But, he adds, "tremendous though these losses may be, they are not nearly

Inquiries about books reviewed in the Literature department should be addressed to the American Hospital Association Library — Asa S. Bacon Memorial, 18 E. Division Street, Chicago 10. The department is edited by Helen V. Pruitt, librarian.

as great as the losses due to the toxic destruction of tissue protein itself." In severe surgical conditions a patient can lose more than three pounds of muscle tissue in 24 hours. The patient must be supplied with the minimum nutritional requirements during the first few days when he is unable to eat or drink.

Dr. Pollack and Dr. Elman jointly discuss their experience with the newer postoperative nutritional regimen. They emphasize the astonishing response to such care—accelerated wound healing, reduced incidence of infections and complications, shortened period of convalescence, greater general well-being.

Suitable for showing to all food service department personnel.

Feeding the Patient

(16mm, black and white, sound, 15 min.)

Purchase prints: United World Films, Inc., 1445 Park Ave., New York City 29. $26.43.

Explains the factors that affect appetite and digestion; preparation of the environment and the patient for the meal; proper balance of food and arrangement of the tray; individualized feeding care; and the factors to be considered in after-care of the patient. Shows feeding of both recumbent and up-patient.

For in-service training of dietetic aides to make them cognizant of importance of meals to patients.

The Danger Point

(16mm, color, sound, 12 min.)

Produced by the Public Health Committee of the Paper Cup and Container Institute, 1790 Broadway, New York City 19.

Free loan: Association Films, Inc., 35 W. 45th St., New York City 19. Borrower pays transportation charges.

Purchase prints: Association Films, Inc., 35 W. 45th St., New York City 19. $90.

Discusses the spread of respiratory diseases and their prevention by proper food handling sanitation. Transmission by improperly sanitized glasses is demonstrated. Use of paper cups emphasized.

Dr. Warren, health officer in "Our Town," is called to the microphone to avert panic over the mounting number of colds and respiratory diseases in the city. He calmly explains the seasonal incidence of such diseases, and the year-around effort of the health department to conquer them by the triple means of isolation, immunization, and cutting the channels of infection.

A special sequence, based on a story by H. E. Kleinschmidt, dramatizes the way infected eating utensils may serve as the channel of infection by which respiratory diseases are spread in public eating and drinking places.

At home, too, Dr. Warren points out, much can be done to stop the course of colds and respiratory diseases through the family. The film emphasizes the importance of sanitation in the sickroom, and shows the need for good wholesome food, cleanly served, in the factory and school lunch box.

For showing to health officers, food handlers, dietitians, educators, club groups and schools.

Modern Commercial Dishwashing

(35mm slide, black and white, sound (with record), 10 min.)

Produced by Jam Handy Organization.

On loan from Wyandotte Chemicals Corp., 1113 Statler Bldg., Boston, Mass. Also, the American Hospital Association Library has one print for loan. $4 for 3 days.

Good dishwashing technique. Sanitary methods of dishwashing by both machine and hand operation. Good for training kitchen aides.

Dishwashing Dividends

(16mm, color, sound, 19 min.)

Free loan; Economics Laboratory, Inc., Guardian Bldg., St. Paul 1, Minn.

The complete sequence of the several operations from bussing dirty dishes to the dish pantry; maintenance required to produce clean tableware by machine dishwashing methods is illustrated in detail. An excellent animation sequence shows the internal operation of a dishwasher equipped with an automatic detergent dispenser. Many practical suggestions for management are contained in the film and booklet of the same title, which is designed to accompany this picture.

For use in training kitchen aides.

Protecting Your Profits

(16mm, color, sound, 20 min.)

Produced by Jam Handy Organization.

Free loan: Sales Promotion Dept., American Laundry Machinery Co., Cincinnati 12, Ohio. This 20 minute color film may be shown to hospital laundry managers, hospital officials, and administrators without charge on request.

Perhaps a large percentage of those responsible for power laundry operation appreciate the advantages of modern laundering machinery but are unaware of the manifold details in caring for the machinery and equipment. How to use it properly in everyday operations is revealed visually and orally in this movie.

It is shown that, whether the professional laundry is operated for service or for profit, the objectives are much the same: (1) Most rapid rate of production per pound; (2) highest quality of work; (3) the lowest possible cost.

The scenes following this introductory portion show, in considerable detail, the character and purpose of today's modern machinery and equipment, in actual use. The picture then goes into the basic matter of a good original laundry installation. Use of the proper blueprint templates, proper and efficient placements for the various pieces of machinery and equipment are shown.

Good film, stressing large equipment, proper maintenance and inspection—tie-in between laundry department and engineering department. Primarily designed for commercial laundries, but does mention hospitals and could be shown to hospital laundry managers and hospital engineers.

Chain of Asepsis

(16mm, black and white, sound, 29 min.)

Produced by U. S. Navy.

The American Hospital Association has one print for loan; $4 for 3 days.

Purchase prints: United World Films, Inc., 1445 Park Ave., New York City 29. $35.85.

Emphasizes importance of sterile linens, pre-operative preparation of the patient, scrub technique, preparation of the operating room, and maintenance of chain of asepsis during an operation.

Excellent, not only for training operating room personnel but also for laundry and housekeeping auxiliary groups, to inform the public why operating room charges are necessarily the amounts they are.

Hypodermic Syringes and Needles, Their Care and Function

(16mm, color, sound, part 1—20 min., part 2—25 min.)

On loan: Becton, Dickinson & Co., Rutherford, N.J. Also, the American Hospital Association Library has one print for loan, $4 for 3 days.

Brief history of development of syringes, basic standards, demonstration of types, cleansing and sterilization, preparation, inspection, intradermal, subcutaneous, intramuscular, venipuncture, and intravenous injections.

Part 1 especially helpful for

purchasing agents. Shows factors to be considered in making a durable syringe and needle. Part 2 for nursing staff—outlines explicit instructions for cleansing and sterilizing. Helpful in training of nursing aides.

Isolation Technique

(16mm, black and white, sound, 18 min.)

Produced by U. S. Navy.

American Hospital Association Library has one print for loan. $4 for 3 days.

Purchase prints: United World Films, Inc., 1445 Park Ave., New York City 29. $24.26.

Describes isolation technique that must be employed in communicable disease cases. Includes terminal disinfection.

Excellent; good training not only for nursing staff but also for laundry and housekeeping employees.

Pre-operative Care

(16mm, black and white, sound, 12 min.)

The American Hospital Association Library has one print for loan; $4 for 3 days.

Purchase prints: United World Films, Inc., 1445 Park Ave., New York City 29. $16.76.

Mental and physical preparation of patient for surgery by hospital corpsman. Emphasizes need and methods of allaying patient's apprehension.

Excellent for nursing staff and also nurse aides who may assist in certain of the procedures.

Bathing the Bed Patient

(16mm, black and white, sound, 25 min.)

On loan: Commandant of nearest naval district.

Shows hospital corpsmen using proper procedures in bathing patient; includes technique of making bed.

Good training film for ward aides.

Maintenance of Office Machines

(16mm, black and white, sound, 37 min.)

Produced by the U. S. Navy.

The American Hospital Association Library has one print for loan; $4 for 3 days.

Purchase prints: United World Films, Inc., 1445 Park Ave., New York City 29. $45.41.

Care and maintenance of typewriters, transcribing machines, dictating machines, adding machines and calculators. Shows all different makes of machines and how to fight enemies of dust, dirt, and carelessness.

Excellent training film for office employees.

The Invisible Receptionist

(16mm, black and white, sound, 21 min.)

Prints loaned or made available through local Bell Telephone Co. office in any town. Purchase prints: $34.50.

Tells why being a switchboard operator is harder than being a receptionist, because one has to project the whole personality and gain good will for the company by voice alone.

For training switchboard operators.

Damp Dusting

(16mm, color, sound, 19 min.)

Prints loaned or made available through local Bell Telephone Co. office in any town. Purchase prints: $121.

Shows proper dusting methods; moves slowly but would be excellent for training; time and motion economy in planning work. Manual available to accompany film.

For training housekeeping personnel.

Telephone Courtesy

(16mm, black and white, sound, 25 min.)

Prints loaned or made available through local Bell Telephone Co. office in any town.

Depicts proper telephone manners in any situation.

For instructing all employees and staff in the hospital, not just the switchboard operators.

Front Office Courtesy

(35mm sound slide, 5-color, sound, 15 min.)

Produced by Frederick House for the American Hotel Association. Available on loan from local hotel which has purchased set. Also, the American Hospital Association Library has one print for loan; $4 for 3 days.

Purchase print: American Hotel Association, 221 W. 57th St., New York City 19. $48 for set of 3: This, "Every Employee a Salesman" and "Fire Prevention." These strips require a 35mm projector with a 16-inch turntable for records.

Plays up the vital role of the front office in guest relations and emphasizes courtesy.

Very effective cartoon. Could be used for admitting officers—shown at beginning of meeting to start discussion.

Every Employee a Salesman

(35mm sound slide, 5-color, sound, 15 min.)

Produced by Frederick House for the American Hotel Association. Available on loan from local hotel which has purchased set. Also the American Hospital Association Library has one print for loan; $4 for 3 days.

Purchase print: American Hotel Association, 221 W. 57th St., New York City 19. $48 for set of 3. This, "Front Office Courtesy" and "Fire Prevention." These strips require a 35mm projector with a 16-inch turntable for records.

Impresses hotel employees in all departments with the value of giving proper attention and service to guests as a sales device. Stresses the personalized and internal aspects of selling the guest through courtesy and giving the little "extras" in service.

Cartoons more effective than movies; excellent for employee orientation and training.

By Jupiter

(16mm, black and white, sound, 30 min.)

Produced for Marshall Field & Co. by Wilding Picture Productions, Inc., 1345 Argyle St., Chicago 40. Not available on loan or for rent.

Purchase prints: Wilding Picture Productions, Inc., 1345 Argyle St., Chicago 40. $125, including instructional manual, theater program, souvenir booklet and tie-in talk to follow showings.

Poindexter is "discovered" in the opening sequence by Jupiter and Juno from their vantage point on Mt. Olympus. Jupiter is trying out his waning miracle-working powers and Poindexter looks like a great subject for the experiment. He has just been through a completely miserable day in which everyone had contributed some unpleasantness, beginning as usual, with himself. Through Jupiter's intervention, he gets a chance to relive the day. At each instance where the events of his day had turned out badly, the strains of Jupiter's lyre remind Poindexter to "lead" with a little unselfishness by being kind and courteous as well as thoughtful.

As Poindexter learns to be courteous, he learns that courtesy is contagious. As a result, life becomes much happier for him and for those he meets. This is the picture story, amusing, well cast and skillfully produced.

Good for employee training in courtesy, getting along with people.

How Not to Conduct a Meeting

(16mm, black and white, sound, 10 min.)

Free loan to borrowers who pay transportation costs to and from General Motors Corporation, Department of Public Relations—Film Section, General Motors Bldg., Detroit 2, Mich.

Also the American Hospital Association Library has one print for loan, $4 for 3 days.

(Continued on page 119)

Questions and answers on intern, resident deferments and delays

THE FOLLOWING questions and answers relating to the recall of reserve and National Guard officers were prepared on the basis of information supplied by the Army surgeon general's office. The answers, which were published in the September 2 *Journal of the American Medical Association,* reflect the policies that the current military and national situation dictates. Delays refer to postponement of service for six months or less under the policy of the secretary of defense. Deferments refer to postponement of service under the Selective Service System.

Question: Is a National Guard or Army reserve officer or enlisted man who is a medical student or intern eligible for delay from call to active duty?

Answer: Graduates of advanced course, senior division, ROTC, and members of civilian components enrolled, or who have been accepted for admission, in a recognized school of medicine will be delayed in call to active duty until the end of the fall quarter or semester of their college or university. At the end of the initial specified delay, extension may be requested. Members of civilian components who have not completed at least one year of intern training will also be granted a delay in call until completion of one year's internship.

Question: Is a medical student, intern or resident who is not a member of the reserve or National Guard eligible for deferment from the draft?

Answer: Announcements of policy by the national headquarters of the Selective Service system should be consulted in connection with this question. Provisions for permitting students who are not otherwise deferable under the Selective Service Act of 1948 as amended and who are properly enrolled in certain professional schools (including schools of medicine) and satisfactorily pursuing full time courses leading to graduation, to continue their studies until graduation are contained in Local Board Memorandum 7.

Question: Is a National Guard or Army reserve officer or enlisted man who is in residency training eligible for delay?

Answer: Only those in the last year of their residency are eligible for initial delay. Enlisted men of these civilian components in this category are urged to apply for appointment in the Medical Corps Section of the Officers' Reserve Corps under provisions of Department of the Army Circular 210, of 1948, or to the state adjutant general of the state of their residence for appointment as a medical officer in the National Guard.

Question: What action should be taken by those medical students who are members of line organizations in the National Guard or reserve?

Answer: Medical students who are commissioned or enlisted in the reserve should notify, through their appropriate channel, the chief of their military district as to their status as medical students, if such information is not already, to their knowledge, a matter of official record. In the event of their call to active duty, they may request a delay in such call under the announced policies of the department of the army. Those officers of the reserve who are qualified for transfer to any one of the corps of the Army Medical Service Reserve may submit a request for transfer under the provisions of SR 140-160-1. Such requests should be submitted through the appropriate reserve channels to the commanding general of the army in whose area they reside. Persons enlisted in the reserve who are qualified for appointment in any one of the corps of the Army Service Reserve may apply for appointment under the provisions of Department of the Army Circular 210, of 1948. Medical students enlisted or commissioned in the National Guard are under the jurisdiction of the state adjutant general concerned prior to their induction. Requests for determination of status, commissioning or transfer to the Medical Corps and granting of any delay in call to duty of such persons should be directed to the state adjutant general concerned.

Question: What action should be taken by interns and residents who are members of line organizations in the National Guard or reserve?

Answer: Those officers of the corps who are qualified for transfer to any one of the corps of the Army Medical Service Reserve may submit a request for transfer under the provisions of SR 140-160-1. Such requests should be submitted through the appropriate Reserve channels to the commanding general of the army in whose area they reside. Persons enlisted in the reserve who are qualified for appointment in any one of the corps of the Army Medical Service Reserve may apply for appointment under the provisions of Department of the Army Circular 210, of 1948. Medical students commissioned or enlisted in the National Guard are under the jurisdiction of the state adjutant general concerned prior to their induction. Requests for determination of status, commissioning or transfer to the Medical Corps and granting of any delay in call to duty of such person should be directed to the state adjutant general concerned.

Question: What obligation is incurred by a person accepting a delay or deferment?

Answer: No additional obligation is incurred by reason of acceptance

of a delay in call to duty or deferment. On termination of such delay or deferment, the person is subject to call to active duty on the same basis and under the same procedures as he would have been initially called.

Question: What other individual reserve or National Guard medical officers are eligible for consideration for delay from call to duty?

Answer: (1) Reserve medical officers now pursuing a fulltime postgraduate course of instruction in medicine, at a college, university or similar institution of higher learning until completion of the current academic year of such training. (2) Reserve medical officers whose activity in teaching, research and allied endeavors is considered by the appropriate army commander to be essential to the national health, safety or interest. (3) Reserve medical officers residing in communities the health of which, in the opinion of the appropriate army commander, would be unduly jeopardized if such officers were to be ordered to extended active duty.

Question: How, when and to whom should requests for delay be submitted?

Answer: Requests for delay in call to active duty should be submitted in writing on initial receipt of notification that call to active duty is contemplated. For members of the reserve, such requests should be submitted to the headquarters responsible for the issuance of the notification, as authority has been granted by the department of the army to such headquarters to take appropriate action. Re-delegation of this authority may be made by those commanders to subordinate headquarters commanded by a general officer or to a chief of a military district. Only those requests that cannot be determined at army commander level will be forwarded to the department of the army (the adjutant general, attention AGAO-C) for final appeal. In the case of National Guard personnel, requests for delay should be forwarded to the state adjutant general.

Question: Who is entitled to additional professional pay?

Answer: It is the opinion of the surgeon general, department of the army, that, prior to the issuance of orders calling him to active duty, any medical or dental officer of the ORC or National Guard who volunteers for, and is accepted for, extended active duty for a period of at least 21 months is entitled to be classified as a volunteer under the provisions of Section 203 of the Career Compensation Act of 1949 and to receive additional special pay of $100 per month. This opinion is subject to the confirmation of the comptroller general of the United States.

Pathologists assist coroners

For a year now the services of qualified pathologists have been offered to 88 coroners in Ohio by three medical schools, at Western Reserve University, the University of Cincinnati and Ohio State University. Ohio is believed to be the second state in which such services are available to coroners. For about 10 years Harvard University has been furnishing such services in Massachusetts.

With the services of competent pathologists available at reasonable cost under the new plan, rural areas have the advantage of the same quality of investigations and autopsies as urban centers in deaths which come under the jurisdiction of a coroner.

The following objectives, which may be attained by competent investigations and autopsies by qualified pathologists, are presented in an article entitled "Pathology and the Coroner" in the September 1949 issue of the *Ohio State Medical Journal* by Dr. Frank R. Dutra, of the Kettering Laboratory of Applied Physiology, a unit of the University of Cincinnati College of Medicine.

1. Murders will be recognized as such and will not be mistaken for deaths from natural causes, accidents, or suicides.

2. Facts and objects of evidence will be properly preserved so as to aid in the apprehension and prosecution of persons responsible for homicides.

3. Persons innocent of crime will not be suspected or accused of homicide.

4. Unsuspected hazards to the public will be recognized at the earliest possible time and thus can be brought under adequate control.

The Medical Review department is edited by Charles T. Dolezal, M.D., secretary of the Council on Professional Practice.

Parenteral nutrition

In the March 1950 *Annals of Surgery,* Rice and his associates describe a routine to prepare for operation patients who are considered poor surgical risks. Immediately after operation, 1,000 cubic centimeters of fluid containing amino acids 5 per cent, dextrose 5 per cent, and 60 cc's of 98 per cent alcohol are administered parenterally. The patient usually sleeps or dozes during the four hours required for administration. Morphine is seldom required. In the evening, another 1,000 cc's are given so that within the first 12 hours after operation the patient receives 100 grams of amino acids, 100 grams of dextrose, and 120 cc's of alcohol, a total of 1,472 calories. The following morning the patient is offered food, and if enough is consumed further nutrition by the parenteral route is not given to this patient.

When alcohol is given parenterally in a caloric ratio proportionate to twice the caloric demands of the patient, the blood alcohol content rises rapidly during the first hour, after which it has a tendency to level off. If the blood alcohol level remains fairly constant at .08 grams per 100 cubic centimeters, production of mild sedation and analgesia reduces the need for morphine. Approximately 15 cc's of 98 per cent alcohol per hour in parenteral fluids will provide a practical clinical rate of administration for the average adult.

The authors do not maintain that less well-nourished patients would not get well but only that patients who are provided full nutritional requirements feel better, have more rapid wound healing and less discomfort, are more easily ambulated and experience a shorter postoperative convalescence than patients not receiving this regimen.—C.T.D.

Buying for the hospital in an inflationary economy

CHARLES O. AUSLANDER

EVERYONE WHO IS responsible for the spending of the hospital dollar has been watching with alarm the inflationary processes that have been set in motion since the start of hostilities in Korea.

What caused the sudden spiraling of prices?

Was it "scare buying," the mass hysteria that frightens the consumer into unnecessary purchases?

Was it because no immediate steps were taken to put price control and allocation of scarce or strategic materials into force?

Was it the commodity speculators who "started the ball rolling"?

Was it the step-up in government purchases?

No one can say exactly which one or which combination of forces produced the current situation, but one thing is certain: Hospital purchasing agents are paying considerably more for goods than they did prior to the Korean outbreak, and from all indications the situation undoubtedly will be progressively worse until such time as voluntary or compulsory allocations, priorities and price control are established.

THE HOSPITAL OUTLOOK

What can be said for the supply situation on some of the major commodities used by hospitals?

On x-ray films, one authoritative source has highlighted some of the problems that will affect the supply.

It is felt that the supply of x-ray films for the next quarter will be somewhat tight. There will be an adequate supply but very little surplus to take care of any possible hoarding. A major reason for this is that, today, industry is using x-ray films in larger quantities for industrial applications — applications of a very high priority, such as accelerated aircraft production. Also, the government will be using a considerable quantity at induction centers.

HYPODERMIC SYRINGES

Another major concern is hypodermic syringes and needles, real "bread and butter" items as far as hospitals are concerned. For the next quarter, and for the foreseeable future, hypodermic syringes should be in ample supply for ordinary requirements, with allowance for normal growth but not enough to take care of stockpiling by consumers or distributors in anticipation of shortages.

A commodity which has broken price headlines more than once recently is rubber. Large government purchases of rubber have brought forth an allocation order "R-1" from the federal government that limits the amount of crude rubber available to each manufacturer. This amount is based on his previous requirements.

The type of rubber that is most seriously affected is latex crude rubber—now in short supply. Since, dollar-wise, the use of surgeons' gloves represents a very sizable amount each year for most hospitals, it might be well for administrators to check factors that shorten the lives of surgeons' gloves. Most important in this respect is determination that proper methods of sterilization and exposure are being used in the hospital and that methods conform to recommended standards.

There probably is no more authoritative work on this subject than Dr. Carl Walters' recent textbook, "Aseptic Treatment of Wounds."

Another major category is metal equipment, such as stainless steel operating room furniture, built-in stainless steel cabinets, operating tables, and sterilizing equipment. The delivery picture on these items will become progressively worse, due in no small measure to the fact that many hospitals which have received grants under the Hill-Burton act are now reaching the phase of construction where an accelerated amount of this type of capital equipment will be required. This, coupled with the anticipated requirements under our stepped-up preparedness program, will certainly overtax the productive capacity of the major producers of this equipment.

It may well be that many of the items used by hospitals will be in "tight supply." There is not much that the purchasing agent can do when higher prices are quoted to him for items that are needed for continuance of the hospital's smooth operation. What he can do, however, if he feels that the price being asked is excessive, is to compare prices for similar items by different manufacturers. This he should do.

PRICE CONTROLS

If prices become inflated to an unwarranted degree, price controls definitely can be expected. This was mentioned by President Truman in his speech to the public on Sept. 9, 1950:

As for prices and wages, the government is not putting on mandatory ceilings at this time. But we will impose ceilings vigorously and promptly when the situation calls for them.

So that we may be ready to impose price ceilings when they are needed, I have today issued an order under the Defense Production Act requiring business men to preserve the records of their prices and costs during the base period of May 24 to June 24, 1950. This means that information will be available to set ceilings at fair levels, and to identify the sellers who have taken advantage of the present emergency.

Mr. Auslander is director of the Joint Purchasing Corporation, New York City. Adapted from a paper presented at the American Hospital Association Convention, Atlantic City, September, 1950.

THE ARMSTRONG X-4 BABY INCUBATOR IS STILL LOW IN COST STILL LOW IN OPERATING COST

THE GORDON ARMSTRONG COMPANY, INC.

To Hospital Administrators:

ABOUT PRICES

I'm writing you this memo October 9th to appear in all of our November advertising. By the time you read it anything can have happened but regardless of conditions in November our basic thinking will be the same. We shall fight against any increase in our selling price. This goes for any product we design and sell and applies particularly to the Armstrong X-4 Baby Incubator.

For 7 years now we have done this and in 7 years we have increased our Baby Incubator price less than 3 and ½ per cent and we have sold over 12,000 Baby Incubators. That's a record we're proud of. We shall keep on fighting costs.

Here is our pledge to you. We will not increase the price of the Armstrong X-4 Baby Incubator except as a last resort. As time goes on we may be forced to because we simply can't help it but we do not see it yet and we shall continue to fight against it.

Don't be "panicked" into buying anything. Don't order Armstrong X-4 Baby Incubators just because some other prices are going up. When you need Baby Incubators then buy an Armstrong X-4 because the price is low, because it is so easy to operate, because it is simple and safe and because back of every Armstrong X-4 Baby Incubator is 12,000 Incubators worth of experience.

We're both washing our necks in the same bucket you know—we're in this fight together. You can help us win by continuing to give us your loyalty and support just as you have for the past 7 years. Trust us to do our part.

Sincerely yours,
The Gordon Armstrong Company, Inc.

Gordon Armstrong
Pres-Treas

WHEN the Armstrong X-4 Baby Incubator was designed, we worked to keep both costs low for Armstrong X-4 users.

Low *first* cost has been accomplished by the elimination of unnecessary selling expense. Savings we have made in selling costs are passed along to X-4 users by holding down the price. As a matter of fact our price has increased less than 4% in seven years.

Low *operating* cost is accomplished through clean, simple design and easy control, with replacement parts for those that wear out in normal use available at low prices.

But these factors do not mean that the X-4 is cheap in *any* sense. All important construction materials and controls used throughout the X-4 are the finest on the market.

So, remember, the first cost on an X-4 is low, the operating cost is low. As long as it is humanly possible, we intend to keep it that way, as the users of over 12,000 Armstrong X-4 Incubators will tell you. Write for a complete description of the X-4 and you'll quickly realize why.

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"Back of every Armstrong X-4 Baby Incubator is over 12,000 incubators' worth of experience."

© The Gordon Armstrong Co., Inc.

Many of the items that are being purchased today have been raised in price on an "across-the-board" basis. The purchasing agent must assume that these increases, particularly in the case of manufacturers who have been in operation for a good number of years, have been carefully and equitably figured.

Realizing this, and also realizing that hospitals will be faced with possible shortages and price increases, it then becomes a matter of urgency for the individual hospital purchasing agent to be doubly sure of the supply picture on items that he purchases and to be aware of what alternate materials may be available for items in short supply or that may come into short supply later.

VITAL ROLE

During the last war, the purchasing agent and his department were recognized as being most essential to the uninterrupted operation of the hospital. In the months ahead, the purchasing agent again will have to assume this important role. Prior to the outbreak of hostilities in Korea, we found ourselves, on many items, to be in a buyer's market. That picture has now changed. No longer will the purchasing agent be expected to act as a requisitioning agent trying to get the best possible prices for good-quality hospital supplies. It will now be his duty, a duty in many instances overlooked, to impress upon the using departments that there are such things as substitutions, simplification and standardization.

In many instances, purchasing agents' suggestions for simplification have been overruled because of the often expressed tradition that "such and such has been done or used in the past and therefore should not be changed now."

This attitude on the part of the using departments has no place in our present emergency.

A most important function of the purchasing agent is study of hospital supplies with a view toward simplification. There may be a variety of different sizes of a particular item in inventory which can be simplified, resulting in less capital being tied up and in a lessening of the number of categories to be filled.

Those who purchased during the war years will remember well the simplifications put into effect on many items — simplifications that brought no untoward effects.

The Purchasing department is edited by Leonard P. Goudy, purchasing specialist.

DEPARTMENT HEAD MEETING

Hospital purchasing agents, if they have not already done so, should lose no time in arranging a meeting, through the administrator, with all department heads. At such a meeting, the purchasing agent should explain to them the problems that lie ahead. Their cooperation should be enlisted and they should be made to realize that such suggestions as may be made to them are a matter of necessity.

Through effective cooperation between the purchasing agent and department heads, the best interests of the hospital can be served. If the present supply situation becomes aggravated, there may be many times when support and understanding of department heads will be required. Through their expert knowledge of the use of the commodities required in operation of their departments, they will be able to assist the purchasing agent materially, possibly suggesting substitutions or changes in routine that would simplify the procurement problem.

In an emergency, it is always important that purchasing agents see as many salesmen as possible. Many hospital supply salesmen, through their background and travels throughout various sections of the country, can render invaluable service by giving advice on possible substitute materials for items that are not readily available or by describing simplifications that they have heard about at other institutions.

A survey should be made of the various items of capital equipment now in use at the hospital, such as laundry equipment, sterilizing equipment, and refrigerating equipment. Every piece of capital equipment has a certain number of years of useful life, after which obsolescence causes it either to not function satisfactorily, or, due to change in design, to be less efficient than a new type.

In such a survey there is again great advantage in calling on various representatives to survey the equipment in their particular fields so that they can make recommendations covering the following points:

Should the equipment be completely replaced?

Can it be modernized and repaired, and if so, how many years of service can be expected after this expenditure?

What spare parts should be ordered?

Most firms are only too glad to perform this service, and it is foresighted to have all of this information completely on file so that a program of action can be mapped out.

Resolutions for wartime

In times of national emergency, hospital purchasing agents are called upon more than ever to exercise good judgment and ingenuity in maintaining an adequate supply of materials necessary to proper operation of the hospital. The author suggests the following checkpoints to guide the purchasing agent in his supply and demand vigilance:

1. Do more price checking and price comparing.

2. Study the supply situation carefully, particularly on those items that may become tight.

3. Check into hospital inventory records and correct anticipatory buying dates to meet existing conditions.

4. Have the administrator of the hospital arrange a meeting with department heads so that they may be told what the hospital's price and supply problems will be in the months to come.

5. Give more thought to substitutions, simplifications and standardization.

6. Start thinking about a conservation program.

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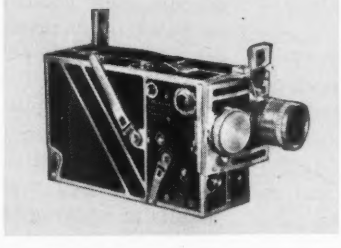

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Use of specification manual saves time and money in purchasing

J. MILO ANDERSON

UNTIL 1948 ONLY a few large hospitals were able to purchase canned fruits and vegetables by specifications. This was due to the fact that all of the necessary information for such purchases was not available in handy form. Only those hospitals that had specialists in purchasing, with the training and the time to look for and compile these specifications, were able to purchase in this manner. In 1947, however, the American Hospital Association's Committee on Purchasing, Simplification and Standardization prepared and in 1948 the Association published and distributed to all member hospitals the "Manual of Specifications for Canned Fruits and Vegetables."

Now anyone in any institution who is responsible for the purchase of canned foods can, from the information found in one book, prepare invitations for bids on specifications for these foods. In addition, this manual provides the information necessary to determine whether or not the foods delivered meet the standards for grade that were specified.

U. S. STANDARDS BASIS

The United States standards for grade are the basis of the specifications in this manual. Also, where United States standards do not specify some important factors in quality, the manual recommends additional minimum requirements. For instance, except in the case of tomatoes, United States grades do not specify minimum drained weight. The manual does that for all products described. The manual recommends the grade, sieve size, range of count or pieces per can and the size of the container that will satisfactorily fill the requirements of hospitals. To assist in the determination of quantity requirements the Serving and Food Chart gives the average number of servings per container.

We have been using this manual in the purchasing of canned foods at the Methodist Hospital for the past two years. The wording of our requests for bids is taken verbatim from the manual. We request that the vendor signify on the invoice the United States standard for grade of the goods delivered. The prices quoted in the first bids we received were an average of $1.50 per dozen less than we were paying previously, and the merchandise was one grade higher than that we had been buying.

The savings that result from the use of specifications in purchasing canned foods are due to several factors: First, when a number of vendors submit bids by grade rather than by label, the buyer can compare prices on goods that are nearly identical as to quality and that are all satisfactory for hospital use. Thus, the selection of the vendor can be made practically on the basis of price alone.

Second, to effect the greatest savings from the use of specifications, canned goods should be purchased in as large quantities as can be stored. Storage is costly. If the hospital buys in quantity and as early as possible after the new crop is packed, the vendor can save the cost of storage and handling and can give the hospital a more favorable quotation. Many hospitals have not been buying in large quantities because of the lack of storage space. They might find it profitable to build new storage facilities just for this purpose.

Since the opening price, offered as soon as a new pack is in, is usually the lowest price, the greatest savings in purchases can be obtained if a year's supply of that item is purchased at that time. It is not necessary to have storage space for a year's supply of all canned goods in order to take advantage of opening prices. The packing time of the various crops is spread over about a six-month period. For instance, green beans and peas are best purchased in about July, tomato products in the fall, and citrus juices in late January or early February. By the time it is necessary to purchase citrus juices, probably half of the green vegetables purchased in July will have been used.

Another saving resulting from the use of specifications as outlined in this manual is that of the time of hospital personnel. After the contents of the manual are familiar, only once a year is it necessary to prepare invitations for the bids and to place an order for each product required. This saves the time of the person responsible for this purchasing because it is not necessary for him to get quotations from sales representatives each time a small quantity of goods is needed. It also saves the time of the vendor, since he does not need to visit a hospital so frequently in order to be on hand, to get the order, each time some goods are needed.

SUBSTANTIAL SAVINGS

The use of specifications in the purchase of canned foods is the most practical way for all hospitals, regardless of their size, to procure these goods. It will result in substantial savings of money due to the price advantages that it makes possible. If it is combined with larger quantity purchasing, an additional saving results. It assures the hospital of receiving the quality of food that it selects. It results in a saving of time for hospital personnel. Food serving institutions other than hospitals have purchased hundreds of these manuals and are using them constantly. In making this manual available, the American Hospital Association has performed a service of great immediate value to all hospitals.

Mr. Anderson is superintendent of Methodist Hospital, Gary, Ind. Presented at the American Hospital Association Convention, Atlantic City, September 1950.

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PURCHASING COMMENT

Purchasing paradise

THE ANNUAL ASSOCIATION convention at Atlantic City last September would have provided a veritable education even if those attending had disregarded the general and sectional meetings and limited their activities to a walk through the commercial exhibits. Almost without exception, worthwhile programs for improving patient care are accelerated when those responsible can look over and talk about the equipment and supplies that are required or considered desirable.

Operating room explosions: One of the major programs of the Association this past year has been the promotion of the new recommendations for control of operating room hazards. The hospital industry has taken up this important project, and it is now possible to get most of the equipment and supplies necessary to do the proper job in the hospital.

For the first time, for example, electrically-conductive shoes were displayed (NP-1). Those who are now considering a remodeling program for the operating room know that an electrical connection must be maintained between operating room personnel and the charge-equalizing conductive floor. Before the advent of the conductive shoe, the one device available was a chain-type grounding attachment fastened to the leg by a garter and making contact with the floor through a brass spring clip attached to the underside of street shoes (NP-2). This device was exhibited also.

The convention visitor did not have to move far to see many other conductive devices which meet the requirements of the new recommendations. Two types of conductive flooring material (NP-3) and a conductive coating for floors (NP-4) also were exhibited at the convention.

For the first time this year also, some operating room wheeled stretchers were equipped with conductive rubber wheels (NP-5). And conductive rubber hose and masks are being made integral parts of anesthesia and suction apparatuses (NP-6).

Disaster: During pre-convention planning, disaster preparations had not entered into the discussions. That at least one exhibit featured a unit designed specifically for hospital care during any disaster is noteworthy.

This unit is a sterilizer that can be put into service at any time and in any area (NP-7). It is heated with a special fuel developed during the war for portable water stills. The fuel is a patented solidified hydrocarbon.

When the hydrocarbon burns in the open air, the flame is characteristic of burning low grade distillate or kerosene. In the burning chamber, however, an intense, blue, smokeless flame is produced.

One of the safety features is that the solidified hydrocarbon does not melt as it burns and therefore will not become a great hazard if dropped on a floor. Undoubtedly the fuel and the heating unit could be made part of any hospital type heating equipment that would be required for meeting emergency service needs.

The bedpan: That hospital essential which has been looked upon with displeasure for decades may not be on its way out, but at least it continues to receive serious attention.

One of the most ingenious devices displayed would eliminate the conventional bedpan entirely. It is a portable flushing toilet combined with a unit that includes complete hand-washing facilities (NP-8). This apparatus was exhibited a year ago at Cleveland as a test model and has since been improved considerably.

A second unit preserves the bedpan, which is worked into a portable commode that can be moved to or away from the bedside (NP-9). The unit permits normal commode posture at the level of the hospital bed.

Patients' beds: A year ago, the ultimate in bed development was exhibited. This was an electrically operated bed that would do almost everything but change the linens. That bed was again displayed (NP-10) as were other models which offered one or more of the features in more conventional models. Patient-controlled, motor-powered spring control now has been brought within normal budget limitations (NP-11).

One of the new ideas that has been worked out for mass production is a bed that can be adjusted in height (NP-12). Thus, the patients can be treated at the regular hospital bed height and then be lowered to the bed height they are accustomed to having in their own homes.

Greatly improved over-bed tables also were exhibited (NP-13). The new models are easy to adjust, have quiet alloy gears, and are so constructed that they are easily kept clean. The more elaborate models include roomy vanity compartments and large mirrors.

Food service: Individualized tray service was the key thought behind many of the exhibits that were of special interest to those responsible for hospital food service. If the convention-goer had been introduced to the new airline type food service through HOSPITALS (June, page 103) he found many items that would fit into such a program.

The vacuum principle for maintaining temperatures is being used in several food serving units (NP-14). One specialty item was a plastic tray containing recessed areas into which can be inserted conventional dishes. Over these are placed special covers made of metal.

Separation of hot and cold foods on a single tray is the special advantage. Other exhibitors showed, in addition to vacuum-type bulk and individual food containers, specially designed serving carts and conveyors.—L.P.G.

Readers desiring to know the names of the firms manufacturing or distributing the products described should address inquiries to HOSPITALS, Editorial Department, 18 E. Division Street, Chicago 10. For convenience, list the code numbers that follow the items about which information is requested.

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Current price trends

IMMEDIATELY AFTER decisive victories by United Nations forces in Korea, prices began to reflect more closely the true supply-demand relationship. Runaway tendencies, produced by "scare" buying, have been checked rather sharply.

This does not mean that inflation itself was checked or will be checked—merely that it probably will proceed more slowly, and that it will be more closely attuned to the real character of the nation's economy.

At the beginning of October, the over-all index for wholesale commodities showed a deceptive reduction of 0.2 per cent from the index of the previous week. The all-commodities index was 169.4 per cent of the Bureau of Labor Statistics' 1926 statistical "normal."

This reduction was merely the subsiding of unnecessarily high prices for farm products and foods. Within the over-all picture there was a heavy ground swell of continued price rises for items such as textile materials, metals and chemical products.

All indications are that inflation will continue. Some informed sources are predicting a 56-cent dollar sometime in the middle of 1951.

An examination of price trends for specific commodities showed this:

In markets for livestock, there were mixed movements that led to an eventual reduction in prices for both hogs and steers. Hog prices showed the greatest drop, sliding down gradually from a high of $23.50 per 100 pounds early in September to a low of $21.17 at the beginning of October. Steers advanced steadily during most of September, and then dropped 25 cents a hundredweight during the last week to $30.25 per 100 pounds.

Mixed movements — all very slight—were apparent in grain markets. It is doubtful if any spectacular increases for these products are on the way in view of large surpluses scattered throughout the nation.

General tendencies for wholesale foods were slightly downward, but there were some increases. In the middle of September, the wholesale price of butter advanced to a new 1950 high of 62.4 cents a pound. Later in the month, a seventh round of price increases for coffee was initiated by four leading manufacturers, who boosted their prices by three cents a pound.

Textile prices moved upward during the month and probably will continue to do so. By October 1, burlap prices had advanced to a new high of 27 cents a pound and cotton to 40.9 cents a pound. Print cloth was higher than it had been since February 1948. Another record toppled at the Sidney, Australia, wool sales when grey marine sold as high as $1.73 a pound. Later in the month, a leading woolen mill announced increases of 42.5 and 47.5 cents a yard on men's and women's wear worsteds.

Although markets for metals and building materials were relatively inactive, economic forecasters predict increases for the months to come. Heavy industries and building industries have just begun to swing into large-scale defense production. This, coupled with anticipated wage increases, is certain to produce price rises for raw materials, semi-manufactured products, and durable goods.

TABLE 1—FOODS DOWN SLIGHTLY

Weekly Index Numbers of Wholesale Prices—1926=100

COMMODITY	Sept. 20 1949	Sept. 27 1949	Aug. 29 1950	Sept. 5 1950	Sept. 12 1950	Sept. 19 1950	Sept. 26 1950	% of Change 9-27-49 to 9-26-50	% of Change 1-3-50 to 9-26-50
All commodities	154.0	152.4	167.2	167.7	169.1	169.8	169.4	+11.2	+12.5
Farm products	163.5	159.8	179.5	179.5	182.0	181.3	180.2	+12.5	+17.1
All foods	163.3	159.6	176.5	177.2	178.9	179.0	177.4	+11.6	+14.8
Textile products	139.2	138.1	149.6	152.8	156.0	161.1	162.2	+17.5	+18.1
Fuel and lighting materials	130.2	130.7	134.5	134.7	134.9	134.9	134.9	+ 3.3	+ 3.6
Metals and metal products	168.8	170.3	174.8	174.7	176.0	176.0	176.4	+ 4.7	+ 4.1
Building materials	189.9	189.5	216.1	218.2	220.7	221.8	221.3	+16.5	+16.3

This weekly wholesale price index is designed as a weekly counterpart of the monthly wholesale price index. It is based on a sample of about one-eighth of the commodities in the comprehensive sample and therefore should be regarded as an indicator of price trends rather than as a final compilation. The monthly index should be used for fuller coverage.

Source: Bureau of Labor Statistics.

TABLE 2—DOLLAR DECLINE SLOWS

Monthly Index Numbers of Wholesale Prices—1926=100

COMMODITY	Aug. 1940	Aug. 1942	Aug. 1944	Aug. 1946	Aug. 1948	Aug. 1949	July 1950	Aug. 1950
All commodities	76.9	99.2	103.9	129.1	169.8	152.9	162.9	166.3
Farm products	65.6	106.1	122.6	161.0	191.5	162.3	176.0	177.5
Foods	70.1	100.8	104.8	149.0	189.8	160.6	171.4	174.6
Textile products	72.3	97.3	98.4	124.0	150.4	138.1	142.6	149.4
Cotton goods	85.6	112.9	115.9	160.0	205.3	170.2	190.7	206.8
Fuel and lighting materials	71.7	79.0	83.2	94.4	136.4	129.6	133.4	134.4
Anthracite coal	79.0	85.7	95.4	113.4	136.0	135.9	141.0	142.1
Bituminous coal	96.2	110.0	120.5	136.7	194.6	188.8	191.9	192.5
Electricity	72.4	62.2	59.0	63.9	65.5	68.5	*	*
Gas	84.5	80.4	76.0	79.5	86.9	88.9	88.3	*
Building materials	93.3	110.3	116.0	132.7	203.8	188.3	207.3	213.5
Brick and tile	90.1	98.7	100.7	126.0	159.2	161.5	167.4	167.8
Cement	90.6	94.2	96.4	105.8	133.0	133.0	135.3	135.5
Lumber	98.4	133.0	154.9	177.6	319.9	277.4	338.0	356.6
Paint and paint materials	84.2	100.1	105.5	113.9	158.4	144.0	138.6	142.1
Plumbing and heating materials	80.5	94.1	92.4	106.3	153.9	154.7	156.4	163.7
Structural steel	107.3	107.3	107.3	120.1	178.8	178.8	191.6	191.6
Other building materials	93.4	103.8	103.2	120.9	173.4	167.3	177.2	178.4
Drugs and pharmaceutical materials	96.2	119.5	112.0	110.1	153.4	125.0	129.1	135.0
Raw materials	69.8	101.2	112.7	145.7	182.3	161.3	175.8	179.0
Semi-manufactured articles	77.0	92.7	94.1	111.9	161.2	147.9	152.9	158.9
Manufactured products	81.0	98.9	100.9	123.9	164.6	149.4	158.0	161.0
Purchasing power of the dollar	$1.300	$1.008	$.962	$.774	$.588	$.654	$.613	$.601

**Figures not available at press time.*

Source: Bureau of Labor Statistics.

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Points on proper installation and care of sanitation equipment

GEORGE K. HENDRIX

WHILE MANY HOSPITALS now have one or more fulltime graduate engineers, there are a great many more, particularly the smaller hospitals, that employ only a maintenance man whom they call an engineer. He receives the title from having worked in that capacity for a period of time. This hospital engineer, maintenance man or whatever he might be called can contribute to proper sanitation in the hospital if he knows what is meant by proper sanitation.

WATER SUPPLY

Very few of us give much thought to the source of the water supply in the hospital for the simple reason that it is usually available when we want it. In almost every case today the water supply is provided by the municipality. If such is the case, the municipality—not the hospital—is responsible for the safe quality of the water. The hospital is responsible only for what happens to that water once it arrives at the building.

In those instances where a hospital has its own well for water for domestic purposes, the hospital engineer should make certain that the well is properly located and properly constructed. If the local or state health department has recommended chlorination of this water as a safeguard, this chlorinator must be kept in good repair and the chlorine residual at various points throughout the hospital must be sufficient to kill the bacterial organisms that may be in the water.

Many hospitals are installing air cooling systems and are using private wells for purposes of obtaining water having a lower temperature. The water from these wells, used for cooling purposes only, is no great problem insofar as its bacterial safety is concerned. The hospital engineer must be sure, however, that in some remote place in the hospital the cooling water pipes and the city water pipes are not connected. He is the one individual in the hospital to know this situation and he must be responsible for seeing that such a direct connection is never made. If one does exist, it should be removed immediately. No valve, either manually operated or automatic, will give protection in operating these two water systems. Valves become faulty after years of use and will permit the flow of water undetected by even the engineer.

Mr. Hendrix is chief of the Division of Hospital Construction and Services, Illinois Department of Public Health. Adapted from a paper presented at the American Hospital Association institute for hospital engineers, St. Louis, April 1950.

Hospital sanitation

In these pages, an authority tells what should be done about:

1. Well water
2. Chlorinator
3. Air cooling
4. Back siphonage
5. Faucets
6. Installation of toilet
7. Care of vacuum breakers
8. Sterilization equipment
9. Bedpan sterilizers
10. Aspirators
11. Refrigerator floor drains
12. Kitchen ceilings
13. Insect control
14. DDT and chlordane
15. Garbage disposal
16. Dishwashing

BACK SIPHONAGE

Even when the municipality is responsible for delivering safe water to the building, it is the hospital's responsibility to take care of that water once it gets inside. This water flows through many pipes which connect to the various plumbing fixtures. From these fixtures it goes through other pipes or sewers out of the hospital. Anyone would agree that connecting these two systems would be the worst mistake any engineer could make. Yet, in many hospitals the engineers permit this very situation to exist. I refer specifically to the connecting link—the plumbing fixture — which innocently can, under certain circumstances, permit the free flow of sewage into the drinking water supply. This simple phenomenon is commonly referred to as back siphonage.

What can be done about it? The correction is almost as simple as the event itself. Many fixtures are of such design that there is no necessity of any direct connection at all between the water supply and the drain. In this group would come the lavatories, baths, steam tables, janitors' sinks, drinking fountains and laundry machines. The water faucets or inlets to these fixtures should be such that the end of the faucet is a safe distance above the *uppermost rim* of the fixture—not the built-in overflow. For a lavatory this gap or air space between the end of the faucet and the highest possible water level in the fixture should be at least one inch. A gap or air space of two inches is necessary for bathtubs. A good general rule of thumb is that the distance always should be twice the internal diameter of the effective water pipe opening but never less than one inch.

Proper installation of faucets is not enough. The engineer must be on the lookout continuously for little things that the other hospital personnel, in all innocence, may do. How many janitors' sinks have a short piece of hose fastened to the faucet and extending into the sink for ease in filling mop buckets? How many faucets in laboratories

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have had pieces of rubber tubing fastened to them and extended into the trough or sink to prevent splashing?

PLUMBING PRECAUTIONS

Most of the toilets used in hospitals are of the direct flush type, utilizing a flushometer valve. This is a deadly fixture if it is not properly installed. By proper installation we mean that the flush valve is equipped with an approved vacuum breaker on the discharge side of the valve, and the critical level of the breaker is at least four inches above the rim of the fixture. Unfortunately the critical level is not marked on all vacuum breakers. Since this critical level is near the bottom of the breaker, however, the bottom of the breaker should be at least four inches above the rim of the bowl. A vacuum breaker on the pressure side of the valve will leak and will give no protection whatsoever.

Since most vacuum breakers have mechanical parts, they may fail just as any other piece of machinery. If a vacuum breaker should leak, the engineer should not plug up the air opening with solder or tape it shut. He should remove it and either repair it or replace it. The purpose of this device is relatively simple. When the toilet is in normal operation the flap valve in the breaker opens and closes with the flow of water. If a vacuum should occur in the water line the flush valve will yield against the vacuum and the breaker then comes into play. The flap valve opens and lets air enter through the vents to satisfy the vacuum. In reality, what happens is that air is pulled in and the contaminated water in the bowl is not siphoned back into the drinking water supply pipes.

In the tank type toilet the vacuum breaker ball cock is the device that gives protection. This unit is quite similar in appearance to the ordinary ball cock with the exception that there is a provision for air to enter the fixture in case of a drop in pressure of the water line. In the case of a tank-type toilet, the chances of siphoning contaminated water from the bowl are remote, but the contents of the tank itself can be siphoned back into the water supply pipe.

The worries about sterilizing equipment are gradually solving themselves, thanks to the advances in sanitation being made by the manufacturers. Most of the sterilizing equipment purchased today is of satisfactory design, and if it is installed by a representative of the manufacturer or by a local man under the supervision of this representative, a safe installation is practically assured. The engineer does have to be on guard, however, because there are still some items of sterilizing equipment that are not satisfactorily designed.

Briefly, the two things to remember about equipment are the water supply and the sewer fittings. With the exception of the water sterilizers, the water connection must always be of an open fitting type, having an air gap of at least one inch, or it should be protected with a properly installed, approved vacuum breaker. By "properly installed" we mean on the discharge side of the valve and at least six inches above the maximum water level in the fixture. In the case of water sterilizers there is no particular concern about sterile water being siphoned back into the drinking water lines but there is certainly a danger if unsterile water should seep into the water sterilizers, especially since these units are generally used for storage of sterile water until used. In this regard, there should always be a bleeder line between the two control valves to permit the escape of unsterile water should it seep through the first valve. This bleeder should not be valved under any circumstances.

The other point to remember with regard to sterilizing equipment is that the waste line should never be directly connected to the sewer. It is common practice to use an open funnel fitting so arranged that all waste lines discharge with a free fall of at least one inch into it. This merely provides the physical break to prevent the surcharge of sewage back into the equipment.

BEDPAN STERILIZATION

Bedpan sterilizers of all designs must have an approved vacuum breaker on the water line located on the discharge side of the flush valve and at least four inches above the maximum water level in the fixture. This applies to hot water lines the same as for cold water. In addition there must be a protective overflow level determined by an opening to the atmosphere. The sewer line need not be equipped with an open fitting. It is not uncommon to find bedpan flushing hoses installed in connection with toilets off patient rooms. These hoses are subject to submergence in the bedpan itself or in the toilet bowl, and for this reason each must be equipped with an approved vacuum breaker located on the discharge side of the main control valve in such a way that all water will pass through the breaker and when the device is not in use it never remains under pressure.

Particular attention must be given to the fact that many of these hoses have an attachment at the nozzle so that the operator may open or close the valve at this point. Nursing personnel must be taught that the main control valve at the wall is to be closed tightly after each use and the hand valve at the nozzle must be opened to dissipate any pressure in the hose. This will permit the working parts of the vacuum breaker to function freely and will tend to keep it operative for a much longer period of time.

ASPIRATOR

Another device which heretofore has received little or no attention has been the water operated aspirator commonly found in the laboratory and frequently in some of the older operating rooms. These devices are particularly hazardous inasmuch as common usage permits the mixture of aspirated, contaminated material with the water supply. To protect the aspirator from back siphonage, an approved vacuum breaker should be located on the discharge side of the valve. There must be an open fitting through which the discharge of the water goes to the sewer, and there must be one or more wide-mouthed jars inserted in the suction line to collect all aspirated material so that it does not come in contact

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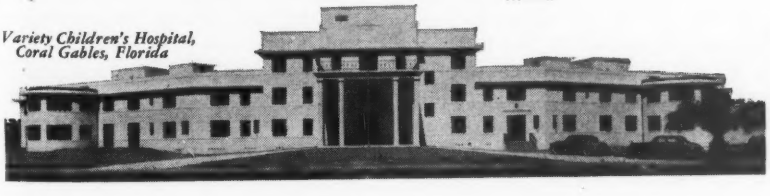

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with the water supply at any time. We must assume that all aspirated material is of an infectious nature and aspirators cannot be considered safe unless these precautions are taken. As an added safeguard, some persons recommend that a check valve be located in the water supply line on the pressure side of the control valve.

I have referred here to "approved vacuum breakers." Some states do not have state plumbing codes as a guide in determining which fixtures are satisfactory and which are not. There are several recognized plumbing laboratories which can provide this service. If an engineer is ever in doubt about whether or not a particular vacuum breaker is approved, it is easy to refer the problem to one of these organizations.

There are many other plumbing fixtures in the hospital, and the basic principles outlined above can be applied to all of them.

DIETARY HAZARDS

It seems to be common practice for a floor drain to be installed inside each walk-in type refrigerator. From the standpoint of sanitation this is not considered good practice, because it becomes easy for sewage to surcharge into the refrigerator. Dietary personnel have always been cautioned that they should never place any type of food directly on the floor of a walk-in box, but it seems to be common practice to find crates of head lettuce, carrots, radishes and celery placed upon the floor. For purposes of cleaning out such a box, the floor drain can be immediately outside the box, and in fact one floor drain often can serve two or three such refrigerators.

In planning a new kitchen or in making alterations to an existing kitchen it is important to remember that exposed pipes at the ceiling should be kept at an absolute minimum. These pipes at the ceiling only serve to collect dust and dirt, which may fall upon food that is being prepared or served. Above all, the sewers are subject to leakage and the contamination from such a source can cause an outbreak of disease in the hospital. A false ceiling below these pipes may make repairs more difficult, but from the standpoint of sanitation it is important.

INSECT CONTROL

It is not at all unusual to hear the remark that it is impossible to keep cockroaches out of the hospital kitchen. I have always maintained that in most cases the presence of cockroaches indicates that the kitchen is dirty. It is recognized that cockroaches enter the building through delivery of food, but if the premises are maintained in a clean, sanitary manner and if a proper insect control program is in force there is no excuse for insects to be present. The common insects troublesome to hospital personnel are the flies and the cockroaches. Both the fly and the cockroach are filthy insects. In general, they live in filthy places, they eat filth and breed in filth. One of the most effective ways to eliminate the fly and the cockroach is to remove the conditions under which they thrive.

For several years, DDT has been thought of as the ideal insect spray. It was far more effective than the ordinary fly spray because the regular insecticide had to be sprayed on the insect to be effective. DDT has the property of being deposited in a thin film upon surfaces that might be touched by the fly or cockroach and, therefore, has a longer killing period than any of the ordinary spray materials. Just recently it has been found that DDT is not as effective against all types of insects as it was thought in the past, and a new material known as chlordane is rapidly taking its place.

Chlordane has the same general properties as DDT and is used in much the same manner. Chlordane may be purchased in either a two or three per cent solution ready for use, or it may be obtained in a higher concentration. For instance, a 75 per cent chlordane solution can be thinned with odorless kerosene or it may be put in a water solution by using the proper water emulsifier. It should be remembered that chlordane is just as poisonous to human beings as is DDT. In certain forms it is inflammable, and it may cause deterioration of asphalt tile or linoleum floors. One gallon of two per cent solution of chlordane is sufficient for about 1,000 square feet of surface. Care should be taken to prevent the contamination of food materials and cooking utensils during spraying periods. Since chlordane has a residual effect it will probably be found that two or three general sprayings during the summer season will be sufficient.

GARBAGE DISPOSAL

In new hospital construction today it is advocated that garbage be refrigerated until it can be disposed of. The space required for refrigeration and can-washing service is not large and is not too expensive in a new construction project. If the hospital uses the typical garbage can setup at the back door, it is important that this area be kept clean and that it be sprayed at frequent intervals to control flies, cockroaches and rats.

Some of the smaller hospitals being built and some of the larger ones having contagious disease units are using garbage grinders for the disposal of garbage and other waste materials. From the standpoint of sanitation this appears sound, although it is important that a check be made with the municipality to make certain that the sewers are large enough to accommodate this extra flow of materials and that the sewage treatment plant can accommodate the additional solids.

Until recently the matter of proper dishwashing in a hospital was a subject that needed much emphasis. The January 1950 issue of HOSPITALS carried an article by Margaret Gillam, dietetic specialist of the American Hospital Association, which, in my opinion, is the finest article that has ever appeared on this subject. It combines in one report the results of research carried on by various organizations and it presents in a clear, concise manner all of the important details a hospital engineer should know about dishwashing procedures. This article points out the importance of the dishwashing machine in the daily operation of a hospital and should convince the engineer of the necessity of preventive maintenance of this equipment and of the need for quick repairs where indicated.

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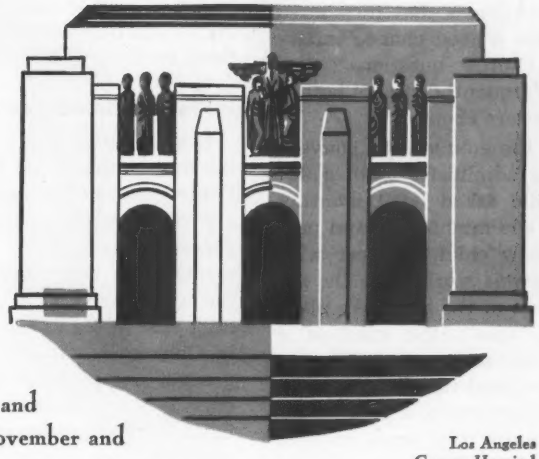
THE HOLIDAYS



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Number XI of a Series

DESCRIPTION—The condition of mind and body that frequently occurs during late November and December, because of the stress of social engagements and the indiscretions of the holidays, might well be termed "celebration disease." Efficient gastrointestinal function and adequate rest will do wonders to alleviate the terrors of this condition. However, human nature being frail, it is sometimes necessary to complement these measures with vitamin supplementation. Where there appears to be excessive indulgence in carbohydrates and similar substances, so that the tissues become depleted or "washed out" of the water-soluble factors of the vitamin B complex, its administration is indicated. *LABORATORY AND X-RAY DIAGNOSTIC CRITERIA*—Fortunately, or unfortunately, laboratory and X-ray criteria for any such temporary condition are unavailable. However, routine laboratory studies may be necessary to differentiate the rather harmless condition just described from something more serious. *DURATION*—Usually a week or 10 days of appropriate treatment will serve to correct any dietary deficiency of this temporary nature. Early resumption of a full diet is highly advisable. *PROGNOSIS*—Excellent. *DRUG THERAPY*—Administration of LEDERPLEX Vitamin B Complex *Lederle,* several times a day as prescribed by a physician, and continued for a week or more, should prove adequate.

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ENGINEERING and MAINTENANCE COMMENT

Engineering literature

ONE REASON Association staff members look forward to the annual convention is that they have at that time a good chance to answer the "little questions" that members frequently will not bother to write letters about.

During the course of a conversation, the administrator of a 60-bed hospital asked what monthly magazine she might read and pass on to a new chief engineer with whom she was working in the reorganization of the hospital's plant operation. That's the kind of a question that seldom finds its way into correspondence, and yet it must be of interest to a great many administrators who want to help their mechanical staffs.

A two-year-old infant in the publication field—*Operating Engineer*—was the answer immediately given. That journal concerns itself with the problems of the man in the smaller plant.

In its September issue, the magazine prints an inquiry from W. P. O'Grady, chief engineer at Irvington House, a cardiac hospital in New York state. The question, asking advice on a simple electrical test panel, was answered with a short, well-illustrated article.

The by-lines and problems of hospital engineers appear from time to time in the publication. John M. Davidson, engineering supervisor of Presbyterian Hospital, New York City, is the author of an article on piping of oxygen that appeared in the magazine in April. Another hospital engineer, William Pfrommer, of St. Joseph's Hospital, Reading, Pa., was the subject of an article in the May issue.

The same issue carried a good short reference to dangerous boiler safety valve hookups.

The chief engineer who is also superintendent of maintenance, in these days when more and more emphasis is being placed on proper lighting, should know something about illumination. That subject is well covered in another article of the June issue that should be required reading for any individual who will have to plan the revamping of lighting systems in the various sections of a hospital.

Plant maintenance conference

Hospital engineers who attended the first annual Plant Maintenance Conference in Cleveland last January reported the experience to be generally rewarding. Announcements have now been made that the conference will be repeated next year in the Public Auditorium in Cleveland, January 15-18. The general chairman of the Conference is L. C. Morrow, consulting editor of *Factory Management and Maintenance.*

There are to be four general sessions and eight sectional conferences. The sectional meetings will include maintenance problems on electrical equipment, power plant and heating equipment, lighting equipment, and problems of the small plant. In addition to the meetings, equipment and materials will be on exhibit.

Building maintenance classes

In-service training classes in building maintenance can be organized in any Michigan community under the Continuing Educational Service of Michigan State College. A choice of eight ten-week courses is now available in any community which can enroll 10 or more persons for any one of the course units.

While some of the courses are specifically intended for school custodians, most of them will be equally applicable to hospital maintenance.

The courses include heating and ventilating, public building cleaning, electrical maintenance, care of grounds, care of floors, and pressure in temperature instruments. Each group is to meet once a week for a period of 10 weeks, with three hours devoted to each meeting.

Carpets and radiant heating

While carpets are not widely used in hospitals, there are some areas to which carpeting is applicable. There has been a question in the minds of some as to whether carpets can be used on floors heated by the radiant heating system.

A study by the Carpet Institute indicates evidence that soft floor coverings such as carpets have little effect on the transmission of radiant heat. The conclusions were further to the effect that the temperature level of radiant-heated floors was sufficiently low that there will be no harmful effect of the heat on the carpet.

Adhesives have now been developed that permit the joining of carpet strips without sewn seams and the fastening of the carpet to the floor without tacks.

Fire exit lock

An easy release fire exit lock with a built-in alarm is now available. According to the announcement, this lock has been approved by the Underwriters' Laboratories and the Casualty Insurance Underwriters Committee.

The door may be opened by authorized persons through the use of a key which prevents operation of the alarm. In an emergency the door will be opened by striking a target and breaking a glass which allows the gong alarm to operate. Thus, unauthorized use of the exit is discouraged since such use requires the breaking of the glass and setting off of the alarm, which is spring-driven.

The obvious advantage of the equipment is that it permits compliance with exit lock requirements and still provides control over the door without the installation of wire burglar alarm equipment. Although the lock is not normally equipped with panic bars, as usually required for fire exits, it is available in that form.—R.H.

The Engineering and Maintenance department is edited by Roy Hudenburg, secretary of the Council on Hospital Planning and Plant Operation.

Further information about materials referred to in these columns may be had by writing to: HOSPITALS, Editorial Department, 18 E. Division Street, Chicago 10.

When seconds count

INHERENT to the practice of medicine is the importance of time—often a few seconds. In an operating room emergency, for example, when fluid therapy must be changed during an infusion. Using Abbott's ampoule-quality solutions and Abbott's unique, completely disposable venoclysis equipment—VENOPAK and Secondary VENOPAK—*this conversion takes less than 30 seconds.* And it is accomplished away from the patient. The needle remains secure in the vein.

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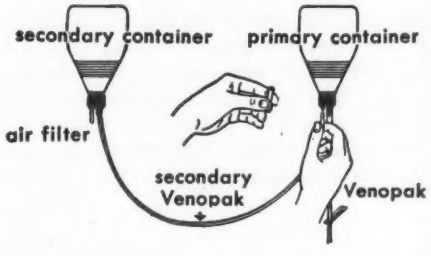

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announces the establishment of

10 SCHOLARSHIPS IN HOSPITAL LAUNDRY MANAGEMENT

sponsored by the

PACIFIC MILLS

HOSPITAL EDUCATION FUND

APPLICATIONS NOW BEING ACCEPTED

To help meet the urgent need for men and women thoroughly trained in new techniques, Iowa State University, in co-operation with the American Hospital Association, will conduct a course in hospital laundry management this spring.

Scholarships are open to men and women presently employed in member hospitals of the American Hospital Association or to those holding written promises of employment by member hospitals on completion of the course.

NEW COURSE IN LAUNDRY MANAGEMENT

As a public service, and as their contribution toward better hospital care, Pacific Mills, through the Pacific Mills Hospital Education Fund, has established 10 full scholarships for this course administered by the American Hospital Association Educational Trust.

Scholarships will cover room, meals, and tuition for 7 weeks during February and March, 1951. Students satisfactorily completing the course will be awarded a certificate by the University.

THE FACULTY—THE CURRICULUM

Regular University staff members will lecture on their special subjects and the courses will be supplemented with practical experience including all necessary use of hospital facilities and laboratories. The Director of University Laundries, Mr. L. A. Bradley, a recognized authority in his field, is a member of the American Hospital Association Committee on Laundry Management.

The curriculum will cover laundry chemistry, textiles, personnel management, laundry management, record keeping and accounting, hospital organization and relations, engineering background, and preparation of reports. The University's excellent laundry facilities which serve a 900-bed hospital as well as the entire campus will furnish practical application of theory.

WHO IS ELIGIBLE . . . HOW TO APPLY

Candidates who are seriously interested in Hospital Laundry Management as a career, or the administrative officer of any qualified hospital having one or more candidates, should request an application blank from Pacific Mills Hospital Education Fund, American Hospital Association, 18 East Division Street, Chicago 10.

Each candidate is requested to submit an outline of his or her professional qualifications, accomplishments, and present position, and state in 500 words or less "Why I Am Interested In Hospital Laundry Management As A Career." Applications close December 20, 1950. Winners will be notified not later than January 10, 1951.

PACIFIC MILLS WEAVERS OF FINE COTTONS FOR A HUNDRED YEARS

Modern machinery and a pleasant environment yield rich returns

JOHN F. WYMER JR.

A STRIKING example of how automatic equipment can be used to replace human labor—at great savings—may be seen in our new laundry at the 115-bed Good Samaritan Hospital in West Palm Beach, Fla.

With a working force of only five persons, operating on a six-day work week, we are able to handle easily all of the linens required in the daily operation of the hospital.

When the laundry was completed in 1948, critical appraisers pronounced it "the most modern laundry in the South." It is expected to save the hospital from $10,000 to $15,000 annually. Plans made when the laundry was still on the drawing board will allow it to expand to more than double its present capacity. When the time comes, there should be ample room for processing all the linens that would be required for a 300-bed institution.

The cost of the laundry, which is a separate concrete building on the hospital grounds, was $93,000. In the first year of operation, we estimated that it saved us about $14,202. This figure was obtained by subtracting 1948 hospital laundry costs — $13,527 — from 1947 commercial laundry costs—$27,729. Hospital laundry costs included $9,389 for salaries and supplies, and $4,138 for heat, light and power. Depreciation was not included. To further clarify the picture, there was no appreciable increase in the amount of flatwork handled in 1948, but there was a large increase in the number of uniforms laundered and finished.

Mr. Wymer is administrator of Good Samaritan Hospital, West Palm Beach, Fla.

EQUIPMENT

The equipment purchased for our laundry was selected with great care. Pains were taken to see that there was a harmonious blending of capacity and need, with just enough capacity left over to provide for emergencies.

Current requirements called for the following:

1. An unloading washer that will turn out 2,500 pounds of clean linen each day.
2. An extractor, with hoist and monorail, that will just match the capacity of the washer.
3. A six-roll flatwork ironer with automatic folder attached.
4. A set of all-purpose presses, (two ponies, one 51-inch press.)
5. A tumbler for towels and rags, operating room gowns, and diapers. (From 200 to 400 diapers are processed daily.)

Another set of presses, a pony washer, and another tumbler will be added when the hospital reaches full growth.

The working force consists of the laundry manager, handling the washing, extracting and wheel sizing; three girls on the flatwork ironer; and one girl to do all of the pressing (no hand ironing required).

In our six-day work week, the laundry handles about 600 uniforms and miscellaneous pieces, and an average of 80,000 pieces of flatwork. The latter ranges from 1,000 to 2,200 pounds a day.

WORKING CONDITIONS

Part of the benefit gained from having dependable automatic equipment in a bright, pleasant building is that we now have much more to sell to the type of employees that we like to hire. More time can be taken away from the tedium of production and given to the maintenance of high employee comfort and morale.

STANDING trim and clean in the Florida sunshine is Good Samaritan Hospital's new laundry building. Critical appraisers have dubbed it "the South's most modern laundry."

TYPICAL of the new laundry's labor-saving equipment is this combination of a modern "self-loading" type washer with a hoist and monorail equipped extractor.

A point of pride is the ventilation system which makes the laundry building almost as cool as the hospital corridors across the way.

Although modern laundry equipment offers the worker advantages of less movement, less labor and less nerve strain, we believe that the institutional laundry must offer more than that to attract and hold its personnel. Even with a wage scale that approximates that of the neighboring commercial laundry, there should be some additional incentives to bring about maximum employee satisfaction.

Consequently, we strive for easier working conditions, a labor day that competes in time and pay with commercial laundries, and greater security on the job. We do everything we can to make labor relations pleasant, and we keep a watchful eye out for labor-saving devices to make the lot of our workers happier.

Most important in this respect is installation of equipment that will eliminate unnecessary steps for our workers. This lessens nerve strain and heightens their feeling of freshness at the end of a day's work.

The self-loading washer has saved many steps. Operations of unloading linen from the washer into the extracting cylinder and transporting it by monorail to the extractor have been made almost completely automatic. Except for the final folding, the automatic folder has reduced the necessary fatigue called for in handling of sheets.

GOOD LIGHTING

With plenty of sunlight streaming in through the windows, or ample fluorescent lighting on grey days, eyestrain has been cut to a minimum. To augment illumination and to encourage cleanliness among employees, the walls are always kept spotlessly clean.

The forced draft ventilating system, consisting of a large ceiling blower and five 48-inch window exhaust fans, provides pure air and affords the workers a pleasant temperature throughout the day.

The fact that the laundry is all on one floor helps us keep close contact with our workers and encourages a friendly, personal relationship between employer and employees, as well as among employees themselves.

The basic idea is to make each job in the laundry as easy and pleasurable as we can. This, we are sure, makes for profitable management and smooth employer-employee relationships.

Through this policy, it is doubtful if there is any other laundry in West Palm Beach that has a higher rate of cooperation between workers and management.

The per-hour productivity of employees at the Good Samaritan Hospital laundry is as high as or higher than that of employees at neighboring commercial laundries.

We recognize that a basic foundation of efficient laundry operation is careful and meaningful measurement of the costs involved, and that improvements can be made only by an intelligent analysis of the various services.

By careful bookkeeping, we are always aware of the true cost for each service in our laundry. We keep a careful record of hourly and daily production and are convinced that, although we do not work on a piecework system (except on presswork), our cost per piece is as low or lower than the cost in plants where the piecework system prevails.

THREE girls handle all of the hospital's flatwork finishing on the six-roll ironer shown above. With it, they process an average of 80,000 pieces each week.

LAUNDRY MANAGEMENT COMMENT

Laundry education

THAT HOSPITAL laundry management is finally receiving the credit that it deserves is evidenced by the attention being paid to it by the leaders of hospital administration.

The spotlight of administrative analysis has been focused for some time now on laundry department shortcomings, and important steps are being taken to bring it to a higher status.

Basic and vital is the need for thorough education of laundry managers to the complexities of their task. Proof of this is the recognition given to this need by the American Hospital Association through a special training program for hospital laundry managers.

Groundwork has been laid for such a course and applications are now being received. The State University of Iowa, in Iowa City, is playing host and is to provide educational facilities through its Extension Division. Beginning on Monday, Feb. 12, 1951, the course will last for seven weeks—through Friday, March 30.

An enrollment fee of $95 will cover the cost of all instruction, including books and supplies, and students will be able to take the latter home with them for future reference.

The instruction planned probably cannot be duplicated. There are courses in hospital administration and there are courses in laundry management—but this is the only course in hospital laundry management.

Under the capable leadership of L. A. Bradley, students will proceed in orderly fashion through the gamut of things a hospital laundry manager ought to know. There will be discussions and training in laundry chemistry, textiles, employee handling, floor operations, record keeping, hospital organization, engineering, and oral and written self-expression. The university laundry and laboratories will be available for practical demonstrations.

Scholarships: Of immediate interest to prospective students are the 10 scholarships—each for $275—being offered to the course through a hospital education fund established by Pacific Mills.

A committee will review applications, which must be postmarked not later than Dec. 20, 1950. Winners will be notified by the end of the first week in January. Qualifications for scholarships are simple and are listed on the applications being sent to all member hospitals.

The deadline for application to the course itself is Jan. 15, 1951. Further information about the course and scholarships may be had by writing to Leonard P. Goudy, Secretary, Council on Administrative Practice, American Hospital Association, 18 E. Division Street, Chicago 10.

Starching uniforms

The administrator of a 90-bed general hospital in Iowa has asked "What is a good method for starching uniforms of hospital employees?"

Now that more and more hospital laundries are including employee uniforms in their lists of items to be processed, such a problem takes on added significance. The answer provided below by John F. Kenney may prove helpful to a number of hospital laundry managers. Mr. Kenney is a member of the Association's laundry management committee and is director of linens and laundry at the New York Hospital, New York City.

"With the process of starching uniforms, it is most important that the formula for cooking and blending starch be followed closely. Only through strict attention to the detail involved will uniform results be achieved.

"A standard formula for cooked starch requires five ounces of dry starch for each gallon of water. A load of nurses' uniforms with a dry weight of 150-175 pounds would require three gallons of this solution plus eight ounces of raw starch.

"Liquid starch should be added to the last operation of the washing formula. With a total running time of 10 minutes, raw starch should be added in the last five minutes.

"Straight cornstarch will provide a 'finish' piece of goods with plenty of body but very little flexibility.

"A 60 per cent corn and 40 per cent wheat mixture will give both body and flexibility."

At what cost a laundry?

The questions presented below are typical of many that arise from time to time in the minds of the administrators of small hospitals. These and others all hinge on the basic problem: Would it be profitable for a hospital of approximately 50 beds to operate a laundry?

This time, the administrator of a 60-bed short-term general hospital, with an average census of 48 patients, would like to know: (1) For this size hospital, what should be considered an average daily poundage of laundry? (2) How many workers should be required to do this amount? (3) What should rates of pay and salaries be?

The following answers were provided by Frank G. Bruesch, chairman of the Association's laundry management committee and administrative assistant at Harper Hospital, Detroit.

"For a 60-bed hospital of the type that you describe, average daily poundage in the laundry should range from 576 to 720 pounds. These figures are based on the generally accepted average of 12 to 15 pounds per patient day.

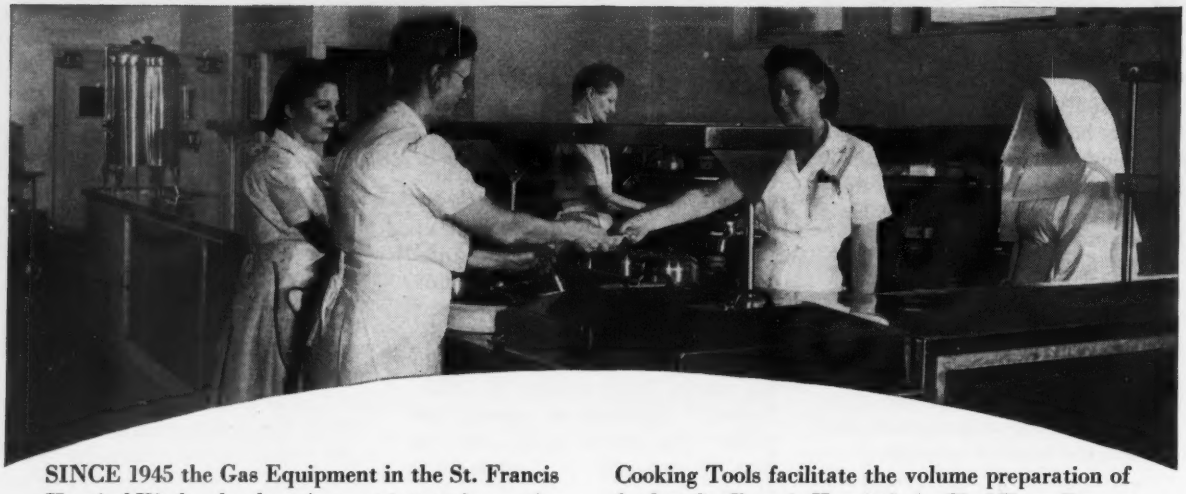
"This amount of laundry probably would require four or five workers.

"Commercial laundries in the vicinity would be helpful in determining salaries and rates of pay. A fair salary for a manager who could wash and extract probably would be about $250 per month. Other employees might receive about $135 per month, or slightly more than the minimum wage of 75 cents an hour."

St. Francis Hospital Claims Capacity and Cleanliness of GAS Equipment Indispensable

St. Francis Hospital, Lynwood, California.
Mother M. Noella, Mother Superior

Sister Mary Wilma, Dietitian, Supervises Food Service



SINCE 1945 the Gas Equipment in the St. Francis Hospital Kitchen has been in constant service, yet its efficiency and cleanliness are just as apparent as when it was installed. That's why the hospital management calls its Gas Cooking Tools indispensable.

In planning the kitchen, the architects arranged the Gas Equipment so that food preparation could be carried out in assembly-line fashion, with many operations going on simultaneously. The method assures that serving deadlines will be met regardless of the occupancy of the hospital.

The productive capacity and versatility of Gas Cooking Tools facilitate the volume preparation of food at St. Francis Hospital. As Chef Tony Boutet points out—"No other fuel I have used gives such a wide range of cooking temperatures. No other is so quick-acting or so clean."

With this background of experience the administrators of the hospital have already selected additional Gas Cooking Tools to provide for expanding food service requirements. Your Gas Company Representative will show you how you can make similar improvements in your food service operations—call him soon.

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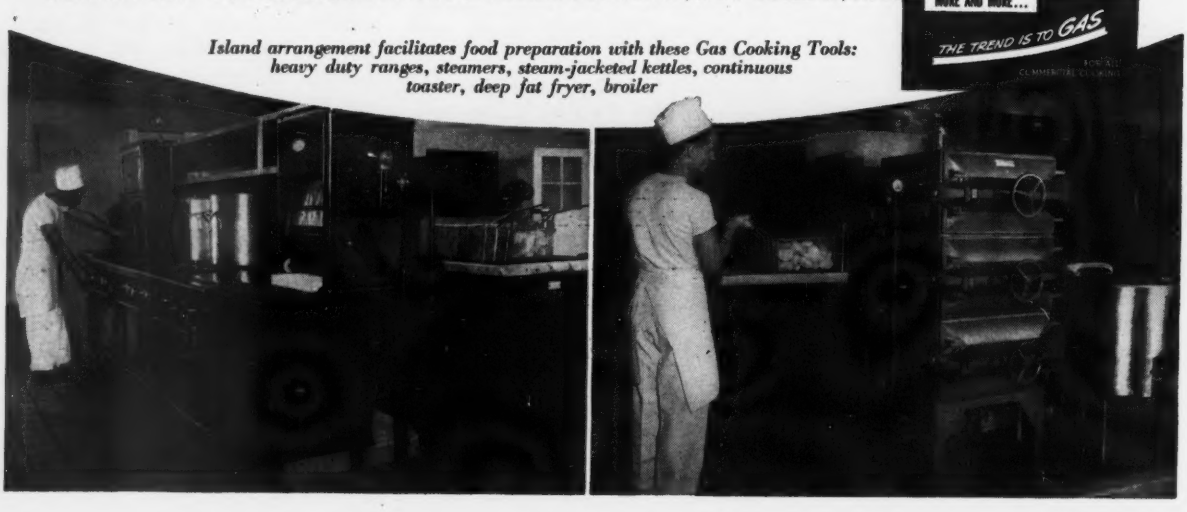
Island arrangement facilitates food preparation with these Gas Cooking Tools: heavy duty ranges, steamers, steam-jacketed kettles, continuous toaster, deep fat fryer, broiler



One hospital's experiences with a commercial formula service

EDWARD C. DeLEAR

TWO HUNDRED SQUARE FEET! Determination of this space requirement was the first discouragement encountered when it was decided to modernize the infant formula room at Saint Francis Hospital in San Francisco. In an institution that was absorbing continually increasing case loads and had been required to utilize every available inch of floor space, this prerequisite prompted the search for an alternate plan.

The necessity for sanitary techniques and procedures in formula rooms. as well as proper organization, supervision and operation, is well known, and the methods developed and recommended by the American Hospital Association's Committee on Procedures and Layout for the Infant Formula Room served as a guide to Saint Francis Hospital's study of modern formula room requirements. Examination of Association Dietetics Specialist Margaret Gillam's report on the committee's manual and consideration of the hospital's own particular problem led to the following conclusions:

1. The high cost of building and maintenance provided an economic factor of consideration in the attempt to provide additional space and equipment for a department that depended upon revenue other than its own to make up its deficit.

2. It would be desirable for several hospitals to centralize their formula preparation and so reduce the cost of supervisory time, release formula room space, and share the costs of depreciation, maintenance, insurance, taxes and utilities.

Mr. DeLear is assistant administrator of Saint Francis Hospital, San Francisco.

See editorial, page 61.

Already available in the San Francisco Bay area were the services of a commercial formula laboratory. It was found that, through this formula service and without the necessity of remodeling or obtaining new equipment, Saint Francis Hospital could be provided with a modern, licensed formula-making facility. After investigation, the hospital contracted for this service. The mechanics of operation, currently in use at Saint Francis Hospital, provide security and cost advantages.

DAILY REQUISITIONS

As a primary step, the charge nurses in the nursery and the department of pediatrics submit daily requisitions of their respective formula needs. Modifications of these requisitions, additional formulas and changed formulas may be made as late as an hour before the scheduled delivery. The feedings are prepared to the hospital's specifications by registered nurses employed by the formula service.

A uniformed driver delivers the feeding requirements (house formulas, special formulas, carbohydrate solutions for post partum feedings and sterile water) once a day. The feedings are contained in individual nursing bottles of the wide-necked, inverted-nipple type, with each bottle labeled as to contents. When the driver makes this delivery, he picks up the equipment from the previous delivery and the requisitions for the next delivery. Emergency service is available 24 hours a day.

Before embarking upon the purchase of formula service, the administrator of Saint Francis Hospital was concerned about the possibilities of contamination from an infectious disease that might occur at other subscribing hospitals, interruption of service due to disaster, or abitrary cancellation of the contract.

The basic principle of sterilization employed by the formula service would seem to eliminate the possibility of contamination.

The formula service is essentially a small-scale milk factory. Factory control procedures, such as using a registering thermometer in a bottle of formula with each batch being sterilized and electronically controlling the pH detergent solution used for washing, provide an important safety factor. Actually, cross contamination is a greater threat in the hospital formula room, because some formula making must be assigned to students and part-time personnel. It is sometimes difficult to provide adequate technical training and security indoctrination to them.

Feeding equipment returned to the formula service from the hospital is first subjected to a caustic soak at 165° F. This removes fat deposits and provides chemical sterilization. Equipment is then mechanically washed at 165° F. and mechanically rinsed at 180° F. The pH of detergent washing solutions is electrically controlled.

All of this work is separated from the area devoted to formula preparation and sterilization. The effect of these procedures is to deliver feeding equipment that, while only considered clean, has actually been subjected to vigorous bacteria control. The important aspect of security in formula making is the elimination of the formula as a medium for the transfer of infections and diarrheas that may develop in and around the nursery. To effect this end, there must be a sharp break in contact between formula making and other phases of infant care. This is effectively done by the techniques described.

In eliminating its own formula-making facilities and depending on an outside commercial laboratory, Saint Francis Hospital required assurance that service would continue without interruption. In case

of emergency there is a kit in the hospital that contains all the material necessary for the preparation of formulas by the pressure technique of terminal heating. This kit can be set up in any space providing running water and a hotplate and otherwise suitable for formula preparation. As a safeguard against this eventuality, however, the formula service has on call two alternate laboratories in nearby areas from which production may be carried on. Test transfers of production to one of the alternate laboratories have been effected with no change in the service schedule. In the event of an area-wide disaster, the multiple facilities of the formula service, along with the emergency kit in the hospital, would appear to approach the optimum.

Service is purchased on a contract basis. The hospital may cancel this contract upon 30 days prior written notice. On the other hand, the contract provides that the hospital be given four months prior written notice before termination of the contract by the service.

The formula service further provides a student nurse training program at no additional cost. The students, who would ordinarily receive training by assisting in the hospital formula room, are given a comprehensive course of instruction in formula preparation and sterilization at the formula service laboratory. The course covers all methods of preparation and sterilization on hospital and home levels. It includes lecture, demonstration, participation, and testing in a specially constructed student training laboratory. This service is directed by personnel fully trained and approved by nursing educational standards.

SURVEY OF EXPERIENCE

After several months of formula service, Saint Francis Hospital has surveyed the situation in the light of its own experience. The basic essentials and recommendations drafted by the American Hospital Association were again compared with the procedures of the formula service. These comparisons are set forth in the accompanying box.

In the transfer of formula preparation to a commercial laboratory, it was natural that some disadvantages would be experienced. The personnel in the nursery and the pediatrics department are required to used the wide-necked, inverted-nipple nursing unit rather than the narrow-necked, upright-nipple type. Unfamiliarity with this unit caused some initial difficulty. Additionally, in the process of terminal heating, a partial vacuum is formed within the unit, which, while protective against the entry of airborne bacteria, makes it difficult to separate the nipple from the cap. A special technique must be learned to accomplish this without trouble.

Difficulty was also experienced by the nurse supervisors in determining their formula needs in advance of delivery for the 24-hour period following delivery. This difficulty expressed itself in requests for a greater number of special deliveries during the first few weeks of operation. The hospital formula room was no longer immediately accessible for use in preparing last-minute or altered requirements. This inaccessibility, however, eliminates haphazard use of the formula room and so provides a safety factor for infants in the nursery. Actually, accurate determination of needs improved

Comparison of essentials

The basic essentials of formula preparation are compared with the procedures of the commercial formula service by Saint Francis Hospital six months after it began using the service.

Basic Essentials	Formula Service
1. A bacteriologically acceptable, terminally heated formula is one on which a plate count shows less than 25 organisms per milliliter.	1. Formulas were, and are, checked at irregular intervals by the Saint Francis Hospital laboratory. They were always within the accepted standard.
2. Terminal heating completely assembled units (bottles filled, nippled and capped) can be relied on to produce a bacteriologically acceptable formula.	2. Terminal heating of completely assembled units of formula is a routine step in formula service processing.
3. The formula room should be used exclusively for the preparation of formulas.	3. The formula room is used exclusively for the preparation of formulas.
4. Preparation of formulas should be functionally separated from the cleaning of equipment.	4. Cleansing of equipment is accomplished in a room physically separated from that used for the preparation of formulas.
5. Thorough cleansing of bottles and utensils—with chemical detergents rather than soaps being used—and clean technique are essential (nipples should be presterilized).	5. Feeding equipment is first subjected to a caustic soak at 165° F. The equipment is then washed in detergent solutions. Nipples are presterilized.
6. If thorough cleansing of equipment and terminal heating are employed, presterilization of bottles and sterile technique are unnecessary and, for efficiency of operation, should be eliminated.	6. It is not claimed that the vigorous and thorough cleaning methods employed by the formula service accomplish sterilization. Therefore, after thorough cleaning the equipment is sterilized.
7. Cooled formulas should be refrigerated immediately at a temperature of 40° F. to avoid incubation of any organism surviving terminal heating.	7. Cooled formulas are immediately refrigerated at a temperature of 40° F.
8. Personnel policies should provide for expert supervision of the formula room, periodic health examination and observation of proper health practices.	8. Personnel are periodically examined. The surgery scrub is routine for all personnel. The formula room is staffed and supervised by graduate nurses. The service meets all requirements of city and state health departments.

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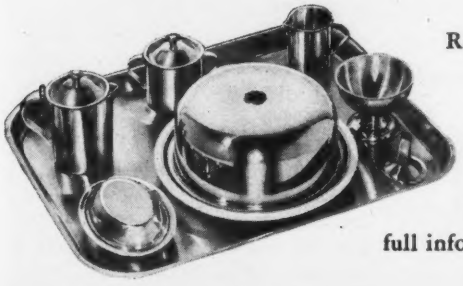

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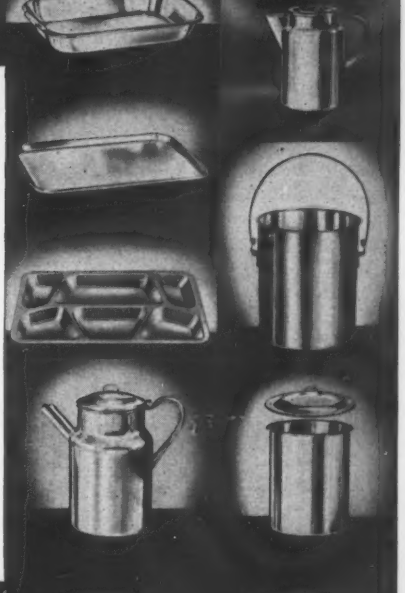

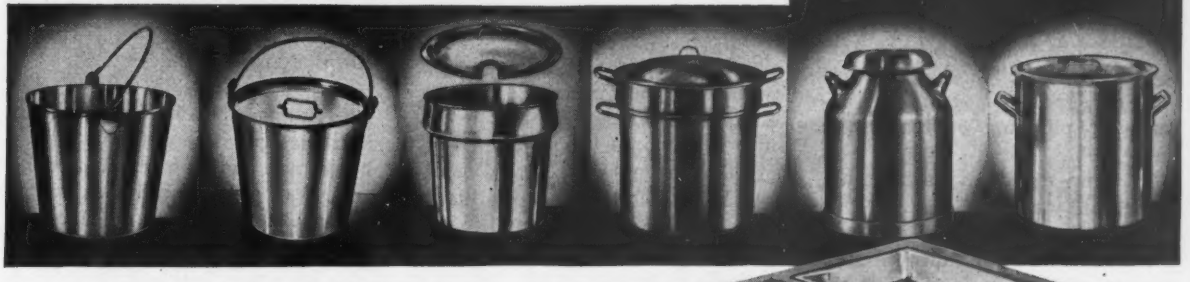

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after the hospital subscribed to the formula service and the system had been in effect for 30 days.

Experience has shown, at Saint Francis Hospital, that infant formula service on a contracted basis has increased security and decreased costs. Also, the administrator automatically acquired an accurate picture of his cost of feeding the infants at the hospital.

Such a service probably will be available only in the larger cities where volume production enables the formula service to operate at a moderate cost. It is recommended that, as in any purchase, the administrator make a complete investigation of the techniques employed by the service, their present performance at contracted hospitals, and the cost factors involved. The material in this article has been based solely on the experience of Saint Francis Hospital with its commercial service. This particular formula service provides the complete feeding needs to nine out of the 22 maternity hospitals in this area. These subscribing hospitals deliver a combined total of 12,000 infants per annum.

DIETETICS ADMINISTRATION COMMENT

Preventing nipple clogging

FREQUENTLY ONE OF the most serious sources of contamination of the infant formula results from the practice of changing the nipple on the formula in the nursery because of plugging or too fast a flow.

In some areas of the country, when fluid whole milk is used, and even in evaporated milk prepared and heated under certain circumstances, a scum is formed on the top of the milk during the terminal heating of the assembled formula unit. This scum will plug the ordinary openings in the nipples.

The holes in a rubber nipple should be large enough to permit the formula to drop rapidly without forming a stream, according to Marjorie Peto, R.N., in an article, "Preventing Nipple Clogging," in the *American Journal of Nursing*, August 1950. Nurses, she states, make holes or enlarge them by puncturing the nipple with a red hot needle. It is not possible to make them all the same size; so the number of holes needed to permit the correct flow of formula will vary. In a large nursery where nipples are interchanged in the preparation of formulas, the weak infant often gets a nipple that requires too much effort one day, and the next day the formula flows so rapidly that he chokes.

Even when nipple holes are checked for rate of flow before terminal heating and when all possible measures are used to prevent nipple clogging, nurses often must interrupt the infants' feedings. Either the punctured holes in the nipples become plugged, or they are the wrong size. These difficulties lead to changing of the nipple when the one sterilized on the unit does not function satisfactorily. It introduces a very weak link into an otherwise unbreakable chain. It is never safe to change a nipple on a formula.

The American Hospital Association recommendation that hospitals make a rigid rule prohibiting change or removal of nipples for any reason during feedings and that another bottle of formula be substituted rather than run the risk of contamination—as published in the manual, "Procedures and Layout for the Infant Formula Room"—is referred to by Miss Peto. This manual suggests that to prevent clogging a crucial incision be made instead of the punctured holes in the nipple.

This type of incision was adopted over a year ago by the Babies Hospital, Columbia-Presbyterian Medical Center, New York City, where Miss Peto is assistant director of nursing service. In theory the crucial cut has a valve-like action. When the baby sucks he obtains milk; when he stops sucking no milk flows. The 4-5 mm. opening is large enough to allow any scum in the milk to pass through. It should not be necessary to change a nipple because of plugging if this type of incision is used.

Several points, she continues, must be considered when the incision is made. It should be in the center of the nipple, and it must be the right size and shape. Manufacturers usually make nipples with three holes. If these nipples are used, great care must be taken to avoid the punctured holes when making the crucial cut. If the punctured holes are in line with the cut, the incision will be ragged. Only a clean cut will have valve-like action. A ragged cut will shorten the life of the nipple.

Many methods for making the incision were tried. These included the use of a razor blade, but it was very difficult to obtain uniform size openings. The method recommended by Ortel Van Horn, who prepares all nipples at Babies Hospital, is described:

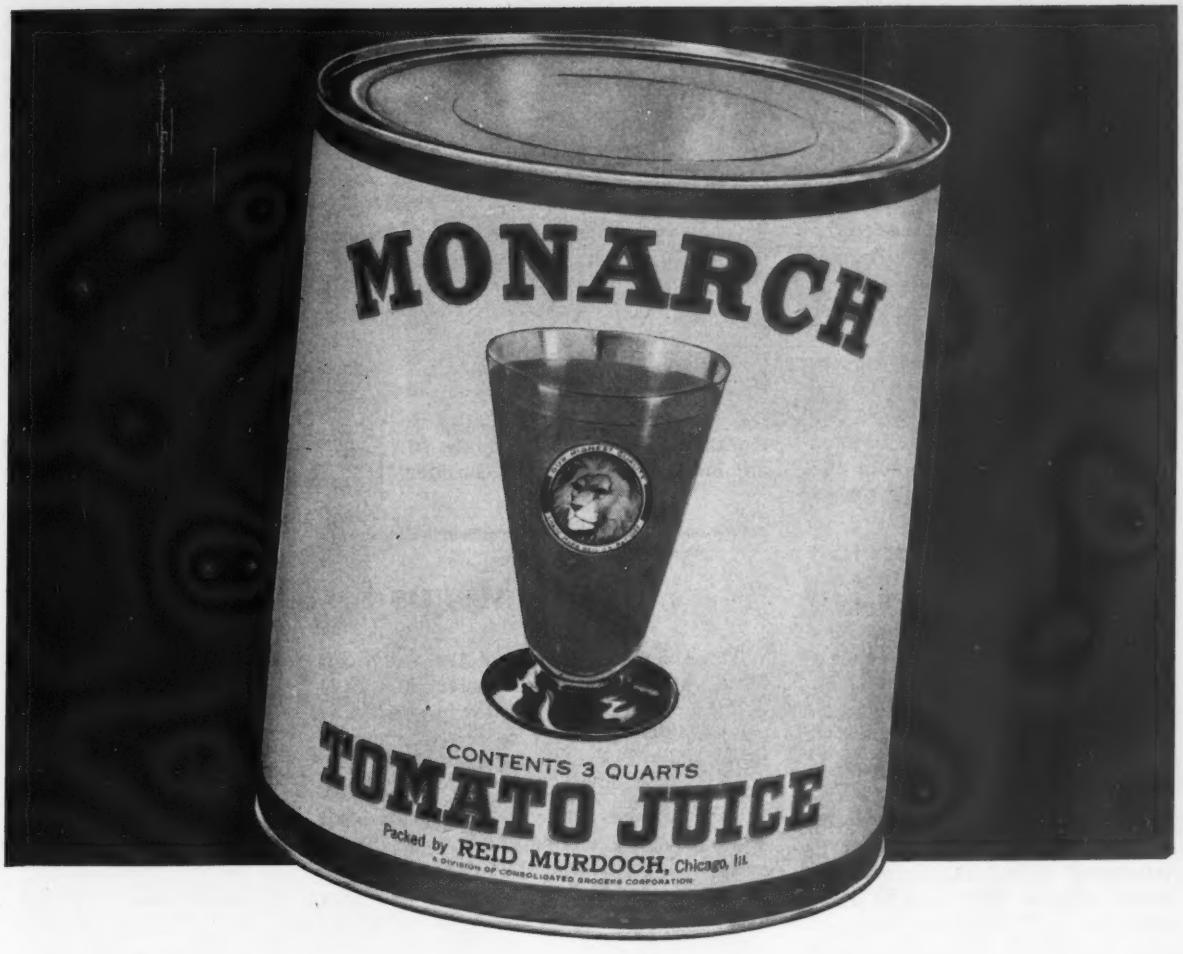
"To make the die, take a star drill and sharpen it so it will give a crucial cut. The die looks like a large nail with a cutting edge shaped to produce a 5 mm. crosscut at one end and a place to hammer at the other end. To make the hole, place the nipple on a piece of leather and put the die inside the nipple. Before hammering be sure the die is going to be in the center. If the nipple tips to one side, you will know you are not right. Once the nipple is straight, hammer the head of the die and a clean cut will result."

Mr. Van Horn tried using wood and metal as a cutting surface, but he thinks that leather produces the cleanest cut.*

In practice, Miss Peto states, the crucial cut has a few disadvantages:

"1. The nurse can no longer test the temperature of the milk by putting drops on her wrist, nor can she shake some of the formula on cereal or egg yolk to soften the food for infant feeding. At Babies

*Nipples with the crucial incision are now made by machinery and are available commercially. Information concerning this manufacturer may be had by writing to: HOSPITALS, Editorial Department, 18 E. Division Street, Chicago 10.



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Hospital the nurse tests the temperature by placing the bottle against her wrist. The food is thinned by using either sterilized tap water or glucose water. All new staff nurses must be told that fluid cannot be shaken out of a nipple with a crucial cut.

"2. The valve-like action of the incision depends on the baby's sucking power. Some very sick infants do not have the strength to suck with enough force to complete their feeding. Nurses have discovered that if they hold the infant's cheeks together with two fingers, they can open the incision in the nipple while it is in the baby's mouth. This requires skill and gentleness.

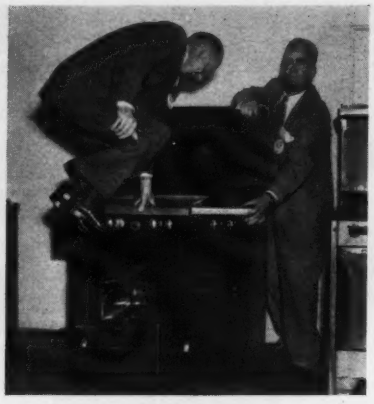
"3. An experienced person must check the nipples before they are used. The incision in a soft nipple opens so readily that the baby may get too much formula and choke. The nipples are discarded if milk flows when the bottle is inverted. They last about four weeks.

"4. The babies seem to become accustomed to the amount of sucking force needed to get their feeding. Some of them are so used to punctured holes that they choke when nipples with crucial incisions are used. However, the nurses know that if the baby balks at one feeding he will probably take the next. Most infants change their habits easily."

Nipples with crucial cuts are used for all infants, including premature babies, at Babies Hospital.

Time and temper savers

▶ **Preflush dishwashers:** Many dishwashing innovations, designed to make life easier and to increase output, are gaining favor in hospitals. Dishwashing machines with preflushing devices now are accepted as a definite asset in the dietary department. Some of these preflushers are home-made, and there are also a number on the commercial market. One manufacturer announced a machine with a built-in preflush chamber and an automatic preflush spray. It has a dial-type flush-mounted thermometer and vertical-sliding leakproof doors. Depending on size, this product reportedly can wash 2,400 to 6,000 dishes per hour.



▶ **Oven door hinges:** A publicity stunt serves as a good reminder of an important point to consider when selecting a new range. A photograph showed the company's division manager jumping up and down on an open oven door. It was his way of showing that the door hinges could stand the most severe abuses.

Although such demonstrations should not be required routinely, the point is well made. Attractive appearance has its merits, but a warped oven door or a broken hingle can completely disrupt kitchen operations while awaiting the repairman.—M.G.

Further information about products referred to in these columns may be had by writing to: HOSPITALS, Editorial Department, 18 E. Division Street, Chicago 10.

Master Menus for December

THE DECEMBER SERIES of the American Hospital Association's Master Menu is printed on this and the following pages.

These menus reduce to a minimum the number of diets, simplify planning, decrease costs and conserve food preparation time. The general diet forms the basis of the seven most commonly used special hospital diets. All except the liquid diets have been planned to include the nine food essentials and servings required for nutritional adequacy.

Consideration is also given flavor, variety, attractiveness and general acceptance by patients. Color is a factor, and color combinations must harmonize. Foods in each meal are planned in a variety of forms, not all flat, high or round but a pleasing combination of shapes. Consistency, too, is important, and here the accent is on variety. If some foods are served in a soft form, a crisp food is included in the meal. Flavor gives zest to a meal, and this aspect receives consideration in the planning. The menus are adaptable for selective service by greater variety in the choice of the two dinner and supper meats.

To use these menus, (1) read the selections for the general (boldface type) and seven special diets, (2) type the day-by-day menu suggestions on transfer slips, spaced and numbered to correspond with the Master Menu wall charts, and (3) attach the completed slips on the spaces and corresponding numbers on the breakfast, dinner and supper wall charts.

Additional blocks of perforated transfer slips and Master Menu kits may be purchased from the Association, 18 E. Division Street, Chicago 10.

December 1

1. **Half Pink Grapefruit**
2. Orange Juice
3. **Shredded Wheat or Hominy**
4. **Soft Cooked Egg**
5. Link Sausage
6. **Sweet Rolls**

7. **Essence of Celery Soup**
8. **Crisp Crackers**
9. **Baked Whitefish, Parsley Lemon Butter**
10. Broiled Whitefish
11. **Scalloped Potatoes**
12. Potato Balls
13. **Sliced Beets**
14. Wax Beans
15. **Mixed Vegetable Salad Bowl**
16. **Herb French Dressing**
17. **Coconut Lemon Cream Pie**
18. Lemon Cream Pudding
19. Raspberry Gelatin
20. Fresh Pear
21. Apple Juice

22. **Boston Clam Chowder**
23. **Oyster Crackers**
24. **Tomato Aspic with Shredded Cabbage—Egg Salad Sandwiches**
25. Poached Salmon—Spinach
26. Poached Salmon—Spinach
27. Riced Potatoes
28. ———
29. **Carrot Sticks and Radishes**
30. ———
31. **Pear and Plum Compote**
32. Canned Pears
33. Baked Custard
34. Unsweetened Plums
35. Blended Juice
36. ———

December 2

1. **Tomato Juice**
2. Tomato Juice
3. **Oatmeal or Crisp Rice Cereal**
4. **Poached Egg**
5. Crisp Bacon
6. **Toast**

7. **Consomme**
8. **Melba Toast**
9. **Glazed Ham Slice**
10. Roast Leg of Lamb
11. **Baked Sweet Potatoes**
12. Fluffy Rice
13. **Broccoli**
14. Julienne Carrots
15. **Sea Dream Salad (Shredded Cucumber in Lime Gelatin)**
16. **Thousand Island Dressing**
17. **Steamed Chocolate Pudding—Hard Sauce**
18. Chocolate Pudding
19. Lime Gelatin Cubes
20. Fresh Pineapple

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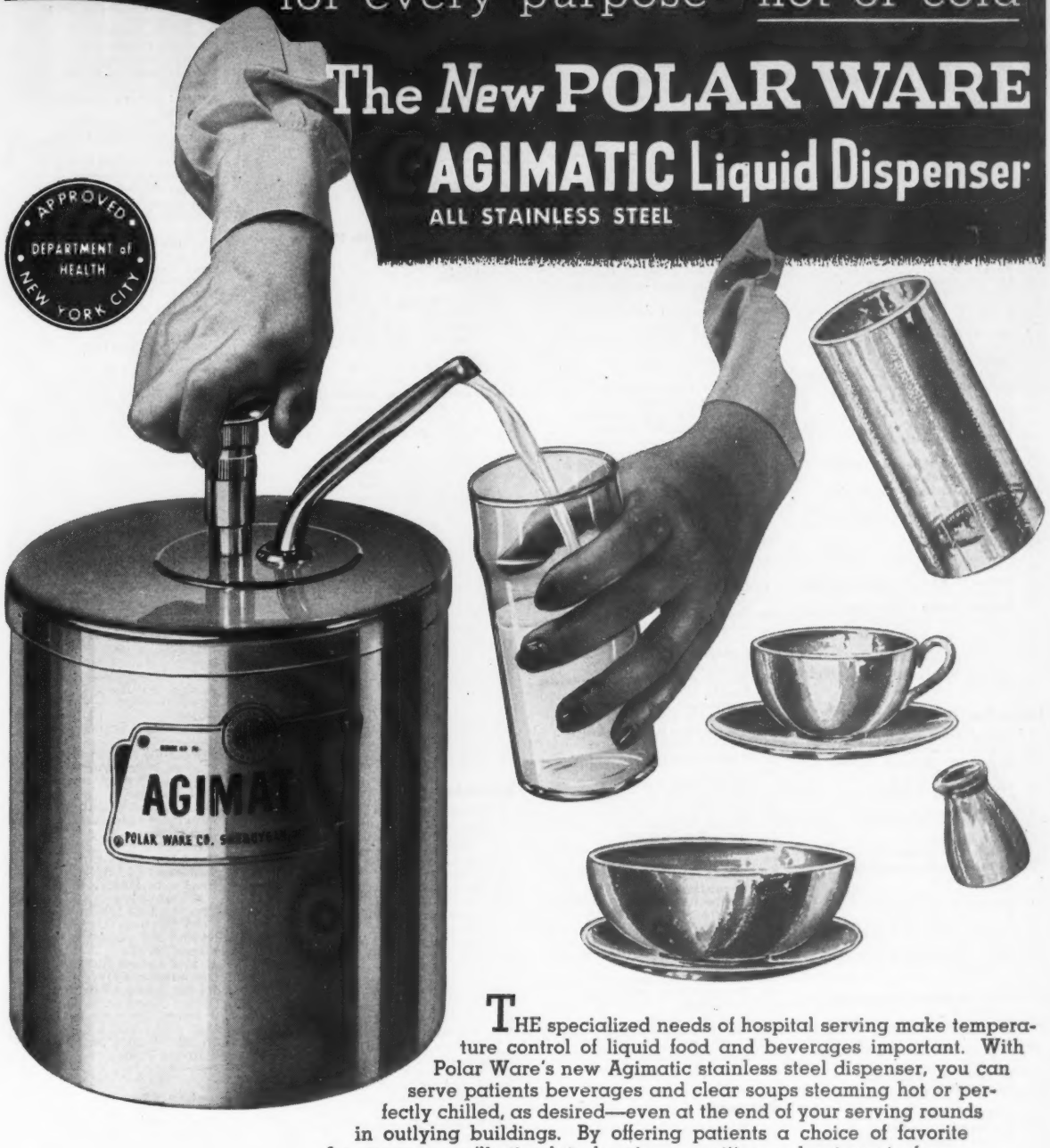

THE specialized needs of hospital serving make temperature control of liquid food and beverages important. With Polar Ware's new Agimatic stainless steel dispenser, you can serve patients beverages and clear soups steaming hot or perfectly chilled, as desired—even at the end of your serving rounds in outlying buildings. By offering patients a choice of favorite beverages, you'll stimulate lagging appetites and cut waste from unfinished glasses or cups. Patented construction makes Agimatic 100 per cent sanitary . . . and the patented pump agitates the entire content at every stroke to assure uniform servings. No wonder hundreds are already in use. Ask the supply houses calling on you for a demonstration. The best of them carry Polar Ware . . . or, if you prefer, write for the Agimatic bulletin.

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21. Apricot Nectar

22. **Turkey and Rice Soup**
23. **Saltines**
24. **Grilled Chopped Steak**
25. Broiled Beef Pattie
26. Broiled Beef Pattie
27. Stuffed Potatoes
28. **Green Peas**
29. **Tossed Salad**
30. **Italian Dressing**
31. **Spiced Applesauce—Hermits**
32. Applesauce
33. Chocolate Pudding
34. Unsweetened Applesauce
35. Orange Juice
36. **Bread**

December 3

1. **Fresh Grapes**
2. Grapefruit Juice
3. **Corn Flakes or Rolled Wheat**
4. **Scrambled Egg**
5. Grilled Ham
6. **Toast**

7. **Mushroom Bouillon**
8. **Saltines**
9. **Roast Beef au Jus**
10. Roast Beef
11. **O'Brien Potatoes**
12. Riced Potatoes
13. **Mashed Hubbard Squash**
14. Asparagus Tips
15. **Head Lettuce Salad**
16. **Thousand Island Dressing**
17. **Strawberry Sundae**
18. Raspberry Sherbet
19. Raspberry Sherbet
20. Fresh Fruit Cup
21. Pineapple Juice

22. **Cream of Broccoli Soup**
23. **Crisp Crackers**
24. **Welsh Rabbit on Melba Toast**
25. Welsh Rabbit on Melba Toast
26. Omelet—Chicken Livers
27. Baked Potatoes
28. **Green Beans**
29. **Tomato and Parsley Salad**
30. **French Dressing**
31. **Royal Anne Cherries—Frosted Fruit Bars**
32. Royal Anne Cherries
33. Vanilla Ice Cream
34. Unsweetened Cherries
35. Mixed Fruit Juice
36. **Bread**

December 4

1. **Sliced Orange**
2. Orange Juice
3. **Granular Wheat Cereal or Puffed Rice**
4. **Soft Cooked Egg**
5. Crisp Bacon
6. **Raisin Bread Toast**

7. **Beef Broth**
8. **Crisp Crackers**
9. **Lamb Steaks with Minted Dressing**
10. Broiled Lamb Steaks
11. **Parslied Potatoes**
12. Parslied Potatoes
13. **Whole Kernel Corn**
14. Chopped Spinach
15. **Raw Vegetable Relish Plate**
16. ———
17. **Ice Cream Cake, Grape Sauce**
18. Rebecca Pudding—Grape Jelly
19. Rebecca Pudding—Grape Jelly
20. Grapefruit Sections
21. Blended Juice

22. **French Tomato Soup**
23. **Toasted Crackers**
24. **Potato Salad—Beef Relish Sandwiches**
25. Minced Beef—Diced Beets
26. Cold Roast Beef—Diced Beets
27. Baked Sweet Potatoes
28. ———
29. **Celery and Olives**
30. ———
31. **Baked Peach Dumpling***
32. Lime Sherbet
33. Lime Sherbet
34. Fresh Grapes
35. Grapefruit Juice
36. ———

*Recipes may be obtained by writing to: HOSPITALS, Editorial Department, 18 E. Division Street, Chicago, 10.

December 5

1. **Fresh Pear**
2. Blended Juice
3. **Wheat and Barley Kernels or Farina**
4. **Scrambled Egg**
5. Crisp Bacon
6. **Toast**

7. **Consomme Royal**
8. **Whole Wheat Wafers**
9. **Baked Meat Loaf**
10. Broiled Beef Pattie
11. **Potatoes au Gratin**
12. Cubed Potatoes
13. **Green Peas**
14. Sliced Carrots
15. **Shredded Green and Red Cabbage**
16. **Peanut Salad Dressing**
17. **Dutch Apple Pie—Cheese**
18. Baked Rice Custard
19. Lemon Rennet-Custard
20. Delicious Apple
21. Cherry Nectar

22. **Cream of Corn Soup**
23. **Saltines**
24. **Cold Spiced Ham Roll-ups with Chopped Raw Vegetables—Potato Chips**
25. Broiled Perch—Tender Greens
26. Broiled Perch—Tender Greens
27. Steamed Potatoes
28. ———
29. **Sliced Tomatoes on Watercress**
30. **Mayonnaise Dressing**
31. **Lemon Layer Cake**
32. Canned Peeled Apricots
33. Whipped Cherry Gelatin
34. Unsweetened Apricots
35. Pineapple Juice
36. **Cinnamon-Topped Oatmeal Muffins**

December 6

1. **Orange Juice**
2. Orange Juice
3. **Oatmeal or Wheat Flakes**
4. **Soft Cooked Egg**
5. Crisp Bacon
6. **Toast**

7. **Consomme**
8. **Saltines**
9. **Roast Pork with Dressing**
10. Roast Leg of Veal
11. **Browned Potatoes**
12. Parslied Potatoes
13. **Seven-Minute Cabbage**
14. Baked Acorn Squash
15. **Cinnamon Apple Salad**
16. ———
17. **Chocolate Eclair**
18. Canned Fruit Gelatin
19. Strawberry Gelatin
20. Fresh Grapes
21. Grapefruit Juice

22. **Cream of Pea Soup**
23. **Croutons**
24. **Tamalie Pie**
25. Minced Beef on Toast
26. Broiled Steak
27. Riced Potatoes
28. **Asparagus Tips**
29. **Fresh Pear Naturelle Salad**
30. **French Dressing**
31. **Peppermint Stick Ice Cream**
32. Prune Whip
33. Vanilla Ice Cream
34. Half Grapefruit
35. Blended Juice
36. **Blueberry Muffins**

December 7

1. **Tomato Juice**
2. Tomato Juice
3. **Crisp Corn Cereal or Rolled Wheat**
4. **Poached Egg**
5. Grilled Canadian Bacon
6. **Butterscotch Pecan Buns**

7. **Beef Bouillon**
8. **Crisp Crackers**
9. **Oven-Baked Chicken**
10. Roast Chicken
11. **Baked Noodles in Broth**
12. Noodles
13. **Broccoli**
14. Julienne Beets
15. **Molded Cranberry, Apple and Almond Salad**
16. **Cream Mayonnaise**
17. **Cup Custard, Rum Custard Sauce**
18. Cup Custard
19. Lemon Sherbet
20. Unsweetened Pineapple
21. Apricot Nectar

22. **Chicken Broth with Rice**
23. **Melba Toast**
24. **Blueberry Pancakes—Syrup—Crisp Bacon**
25. Crisp Bacon—Carrot Balls
26. Cold Roast Veal—Carrot Balls
27. Baked Potatoes
28. ———
29. **Head Lettuce Salad**
30. **French Dressing**
31. **Orange Ambrosia**
32. Grapefruit Sections
33. Cup Custard
34. Sliced Orange
35. Orange Juice
36. ———

December 8

1. **Tangerine**
2. Apple Juice
3. **Oatmeal or Corn Flakes**
4. **Scrambled Egg**
5. Crisp Bacon
6. **Toast**

7. **Beef Broth**
8. **Saltines**
9. **Salmon Loaf with Mushroom Sauce**
10. Broiled Halibut
11. **Mashed Potatoes**
12. Riced Potatoes
13. **Frozen Baby Lima Beans**
14. Patty-Pan Squash, Lemon Juice
15. **Peach and Seedless Grape Salad**
16. **French Dressing**
17. **Chocolate Angel Food with Chocolate Fluff**
18. Cherry Sponge
19. Cherry Sponge
20. Unsweetened Plums
21. Pineapple Juice

22. **Tomato Juice**
23. ———
24. **Scalloped Oysters**
25. Cheese Omelet
26. Broiled Cod Fillets
27. Parslied Potato Balls
28. **Green Peas**
29. **Celery Curls, Carrot Sticks**
30. ———
31. **Fresh Fruit Cup**
32. Canned Peaches—Chocolate Angel Food
33. Lime Gelatin
34. Fresh Fruit Cup
35. Consomme
36. **Cloverleaf Rolls**

December 9

1. **Sliced Banana**
2. Grapefruit Juice
3. **Puffed Rice or Granular Wheat Cereal**
4. **Shirred Egg**
5. Link Sausage
6. **Raisin Bread Toast**

7. **Consomme**
8. **Celery Wafers**
9. **Pot Roast of Beef—Gravy**
10. Pot Roast of Beef
11. **Brown Rice**
12. Steamed Rice
13. **Stewed Tomatoes**
14. Asparagus Tips
15. **Pineapple and Cheese Salad**
16. **Mayonnaise Dressing**
17. **Queen of Puddings**
18. Orange Floating Island
19. Raspberry Rennet-Custard
20. Unsweetened Cherries
21. Peach Lemonade

22. **Vegetable Soup**
23. **Saltines**
24. **Creamed Mushrooms on Rusk**
25. Roast Veal Loin
26. Roast Veal Loin
27. Mashed Sweet Potatoes
28. **Julienne Green Beans**
29. **Orange Cottage Cheese Layered Salad**
30. **Clear French Dressing**
31. **Spicey Applesauce Torte, Whipped Cream**
32. Vanilla Blanc Mange
33. Vanilla Blanc Mange
34. Fresh Pear
35. Tangerine Juice
36. **Bread**

December 10

1. **Half Grapefruit**
2. Blended Juice
3. **Scotch Bran Brose or Wheat Flakes**
4. **Soft Cooked Egg**
5. Crisp Bacon
6. **Cinnamon Buns**

7. **Beef Bouillon**
8. **Saltines**
9. **Roast Duck with Dry Dressing**
10. Roast Chicken
11. **Mashed Potatoes**
12. Riced Potatoes
13. **Whole Kernel Corn**
14. Spinach
15. **Apple, Celery and Raisin Salad**
16. **Cream Mayonnaise**
17. **Raspberry Ripple Ice Cream**
18. Cranberry Sherbet
19. Cranberry Sherbet
20. Unsweetened Fruit Compote
21. Apricot Nectar

22. **Philadelphia Pepper Pot**
23. **Crisp Crackers**
24. **Cold Cuts—Scalloped Potatoes**
25. Broiled Lamb Pattie—Acorn Squash
26. Broiled Lamb Pattie—Acorn Squash
27. Parslied Potatoes
28. ———
29. **Chef's Salad Bowl**
30. **Chef's Salad Dressing**
31. **Chilled Canned Pears**
32. Canned Pears
33. Baked Custard
34. Unsweetened Peaches
35. Orange Juice
36. **Oatmeal Bread**

December 11

1. **Sliced Orange**
2. Pineapple Juice
3. **Shredded Wheat or Farina**
4. **Poached Egg**
5. Crisp Bacon
6. **Toast**

7. **Chicken Consomme**
8. **Melba Toast**
9. **Brisket of Corned Beef, Mustard Sauce**
10. Roast Loin of Veal
11. **Boiled Potatoes**
12. Boiled Potatoes
13. **Green Cabbage Wedge**
14. Quartered Carrots
15. **Carrot and Raisin Salad**
16. ———
17. **Pineapple Tapioca Cream with Meringue***
18. Tapioca Cream with Meringue
19. Lime Gelatin Cubes
20. Fresh Grapes
21. Grapeade

22. **Beef Noodle Soup**
23. **Saltines**
24. **Veal a la King on Cornbread**
25. Creamed Chicken
26. Cold Corned Beef
27. Baked Potatoes
28. **Sliced Beets**
29. **Mixed Green Salad**
30. **Oil-Vinegar Dressing**
31. **Royal Anne Cherries**
32. Sliced Banana in Orange Juice
33. Soft Custard
34. Fresh Fruit Cup
35. Tomato Juice
36. ———

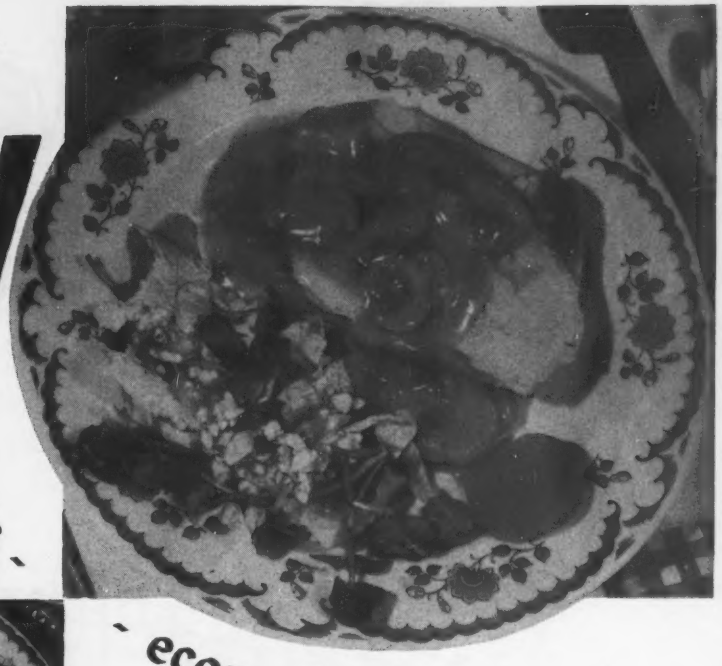
December 12

1. **Tangerine**
2. Grapefruit Juice
3. **Rolled Wheat or Corn Flakes**
4. **Soft Cooked Egg**
5. Link Sausage
6. **Toast**

7. **Beef Broth**
8. **Toasted Crusts**
9. **Roast Fresh Ham**
10. Broiled Steak
11. **Candied Sweet Potatoes**
12. Baked Potatoes
13. **Parslied Cauliflower**
14. Mashed Squash
15. **Stuffed Celery**
16. ———
17. **Baked Apple Pudding, Sweet Nutmeg Sauce***
18. Raspberry Sherbet
19. Raspberry Sherbet

Turkey

popular with patients -



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Amount of turkey per portion .....2½ oz.
Cost of turkey in each portion .....$.133
Cost of turkey plate including trimmings .....$.17

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21. Pineapple Juice

22. **Grape Juice with Lemon Sherbet**
23. ———
24. **Corned Beef Patties**
25. Hot Veal Cubes
26. Hot Veal Cubes
27. Parslied Potatoes
28. **Julienne Green Beans**
29. **Shredded Cabbage and Carrot Salad**
30. **Tarragon Dressing**
31. **White Cup Cakes**
32. Apricot Whip
33. Vanilla Rennet-Custard
34. Unsweetened Apricots
35. Consomme
36. **Raisin Butterfly Rolls**

December 13

1. **Half Grapefruit**
2. Blended Juice
3. **Bran Flakes or Hominy**
4. **Scrambled Egg**
5. Crisp Bacon
6. **Bran Muffins**

7. **Mushroom Bouillon**
8. **Saltines**
9. **Brown Beef Stew with Fresh Vegetables**
10. Roast Leg of Lamb
11. ———
12. Steamed Rice
13. **Baked Sliced Eggplant**
14. Green Peas
15. **Raw Spinach and Radish Salad**
16. **Italian Dressing**
17. **Strawberry Shortcake, Whipped Cream**
18. Cherry Gelatin, Whipped Cream
19. Cherry Gelatin
20. Orange and Grape Cup
21. Apple Juice

22. **Old-Fashioned Potato Soup**
23. **Crisp Crackers**
24. **Liver Bernaise, Stuffed Baked Potatoes**
25. Broiled Liver—Spinach
26. Broiled Liver—Tomatoes
27. Stuffed Baked Potatoes
28. ———
29. **Tossed Salad**
30. **Celery Seed Dressing**
31. **Lime Sherbet**
32. Lime Sherbet
33. Lime Sherbet
34. Fresh Pineapple
35. Blended Juice
36. **French Bread**

December 14

1. **Orange Juice**
2. Orange Juice
3. **Oatmeal or Puffed Wheat**
4. **Soft Cooked Egg**
5. Crisp Bacon
6. **Popovers**

7. **Consomme**
8. **Crisp Crackers**
9. **Roast Stuffed Breast of Veal—Cranberry Sauce**
10. Roast Veal
11. **Mashed Potatoes**
12. Riced Potatoes
13. **Brussels Sprouts**
14. New Beets and Greens
15. **Waldorf Pineapple Salad**
16. ———
17. **Butterscotch Pudding**
18. Butterscotch Pudding
19. Coffee Rennet-Custard
20. Unsweetened Peaches
21. Blended Juice

22. **Cream of Tomato Soup**
23. **Croutons**
24. **Grilled Chopped Steak on Bun—Cole Slaw—Shoestring Potatoes**
25. Broiled Beef Pattie—Carrots
26. Broiled Beef Pattie—Carrots
27. Noodles
28. ———
29. **Asparagus Salad**
30. **Vinegarette Dressing**
31. **Fruit Cup**
32. Canned Fruit Cup
33. Baked Custard
34. Fresh Fruit Cup
35. Tomato Juice

*Recipes may be obtained by writing to: HOSPITALS, Editorial Department, 18 E. Division Street, Chicago, 10.

36. ———

December 15

1. **Half Grapefruit**
2. Tomato Juice
3. **Wheat Flakes or Granular Wheat Cereal**
4. **Poached Egg**
5. Crisp Bacon
6. **Toast**

7. **Essence of Celery Soup**
8. **Melba Toast**
9. **Golden Crusted Haddock Fillets—Tartar Sauce**
10. Broiled Haddock Fillets
11. **Parslied Potatoes**
12. Parslied Potatoes
13. **Stewed Tomatoes**
14. Wax Beans
15. **Sliced Cucumbers**
16. **Chive Cream Dressing**
17. **Lemon Sponge Custard**
18. Lemon Sponge Custard
19. Strawberry Gelatin
20. Fresh Pineapple
21. Pineapple Juice

22. **Cranberry Juice with Orange Sherbet**
23. ———
24. **Tuna-Mushroom Pie with Biscuit Swirls**
25. Creamed Tuna
26. Broiled Salmon Steak
27. Baked Potatoes
28. **Green Peas**
29. **Head Lettuce Salad**
30. **Chiffonade Dressing**
31. **Glazed Baked Apples**
32. Applesauce
33. Lemon Rennet-Custard
34. Unsweetened Applesauce
35. Consomme
36. **Bread**

December 16

1. **Fresh Pear**
2. Blended Juice
3. **Hominy or Wheat and Barley Kernels**
4. **Scrambled Egg**
5. Grilled Ham
6. **Scotch Scones**

7. **Consomme**
8. **Saltines**
9. **Swiss Steak**
10. Roast Leg of Lamb
11. **Stuffed Potatoes, Cheese Topping**
12. Steamed Potatoes
13. **Cauliflower**
14. Sliced Carrots
15. **Bermuda Onion Rings on Lettuce**
16. **Clear French Dressing**
17. **Cherry Cup Cake, Cherry Sauce**
18. Cup Cakes, Cherry Juice Sauce
19. Vanilla Blanc Mange, Cherry Sauce
20. Unsweetened Plums
21. Apricot Nectar

22. **Grapefruit Juice**
23. ———
24. **French Toast—Applesauce—Crisp Bacon**
25. Crisp Bacon—Spinach
26. Broiled Steak—Spinach
27. Riced Potatoes
28. ———
29. **Sliced Tomato Salad**
30. **French Dressing**
31. **Pineapple, Apricot, Plum Compote**
32. Canned Peeled Apricots
33. Raspberry Gelatin, Custard Sauce
34. Unsweetened Bing Cherries
35. Beef Bouillon
36. ———

December 17

1. **Tangerine**
2. Tomato Juice
3. **Corn Flakes or Rolled Wheat**
4. **Poached Egg**
5. Grilled Chicken Livers
6. **Coffee Cake**

7. **Beef Bouillon**
8. **Melba Toast**
9. **Fried Chicken with Cream Gravy**
10. Roast Chicken
11. **Mashed Potatoes**
12. Riced Potatoes
13. **Green Peas**
14. Patty-Pan Squash, Lemon Juice
15. **Molded Bing Cherry Salad**
16. **Cream Mayonnaise**
17. **Vanilla Ice Cream**
18. Ice Cream with Sliced Peaches
19. Raspberry Sherbet
20. Pink Grapefruit Sections
21. Blended Juice

22. **Black Bean Soup—Lemon Slice**
23. **Crisp Crackers**
24. **Creamed Chipped Beef—Baked Sweet Potatoes**
25. Minced Lamb
26. Cold Roast Lamb
27. Baked Sweet Potatoes
28. **Green Beans**
29. **Banana and Orange Salad**
30. **Clear French Dressing**
31. **Angel Food Cake**
32. Angel Food Cake
33. Baked Custard
34. Fresh Pears
35. Mixed Fruit Juice
36. **Cracked Wheat Bread**

December 18

1. **Sliced Banana**
2. Blended Juice
3. **Oatmeal or Crisp Rice Cereal**
4. **Soft Cooked Egg**
5. Crisp Bacon
6. **Toast**

7. **Consomme**
8. **Toasted Crusts**
9. **Veal Fricassee**
10. Broiled Veal Steak
11. **Fluffy Rice**
12. Fluffy Rice
13. **Broccoli Club Style**
14. Carrot Balls
15. **Cranberry and Orange Relish on Lettuce**
16. ———
17. **Lemon Chiffon Pie**
18. Lemon Chiffon Pudding
19. Lemon Chiffon Pudding
20. Orange Slices
21. Grapeade

22. **Chicken Soup Supreme**
23. **Saltines**
24. **Crusty Scalloped Corn—Grilled Canadian Bacon**
25. Creamed Chicken—Asparagus
26. Hot Sliced Chicken—Asparagus
27. Potato Balls
28. ———
29. **Red Apple and Grapefruit Pinwheel Salad**
30. **French Dressing**
31. **Prune Cake, Caramel Icing**
32. Vanilla Blanc Mange, Apricot Puree
33. Vanilla Blanc Mange
34. Unsweetened Cherries
35. Tangerine Juice
36. **Bread**

December 19

1. **Orange Juice**
2. Orange Juice
3. **Bran Flakes or Farina**
4. **Scrambled Egg**
5. Crisp Bacon
6. **Whole Wheat Raisin Toast**

7. **Beef Broth**
8. **Crisp Crackers**
9. **Pot Roast of Beef**
10. Pot Roast of Beef
11. **Golden Crusted Potatoes**
12. Steamed Potatoes
13. **Mashed Hubbard Squash**
14. Wax Beans
15. **Pickled Beets and Onion Rings**
16. ———
17. **Warm Apple Crisp**
18. Soft Custard Fruit Cup
19. Whipped Cherry Gelatin
20. Fresh Grapes
21. Grapefruit Juice

22. **Cream of Broccoli Soup**
23. **Croutons**
24. **Baked Macaroni and Cheese with Flaked Chicken**
25. Baked Macaroni and Cheese
26. Broiled Liver
27. Macaroni and Tomato
28. **Green Peas**
29. **Head Lettuce Salad**
30. **Chiffonade Dressing**
31. **Baked Fudge Pudding—Whipped Cream**
32. Apple Tapioca
33. Soft Custard
34. Unsweetened Peaches
35. Tomato Juice
36. **Hot Cinnamon Rolls**

December 20

1. **Tomato Juice**
2. Tomato Juice
3. **Granular Wheat Cereal or Puffed Rice**
4. **Poached Egg**
   (Omit on General)
5. Link Sausage
6. **Pancakes—Hot Butter Syrup**

7. **Consomme**
8. **Celery Crackers**
9. **Turkey Loaf*—Cranberry Sauce**
10. Sliced Turkey
11. **Candied Sweet Potatoes**
12. Potato Balls
13. **Cauliflower**
14. Sliced Beets
15. **Mixed Green Salad**
16. **French Dressing**
17. **Orange Sherbet**
18. Orange Sherbet
19. Orange Sherbet
20. Unsweetened Apricots
21. Cranberry Juice

22. **Cream of Mushroom Soup**
23. **Melba Toast**
24. **Broiled Ham—Baked Banana in Lemon Syrup**
25. Broiled Lamb Pattie
26. Broiled Lamb Pattie
27. Baked Potatoes
28. **Spinach**
29. **Chickory and Tangerine Salad**
30. **French Dressing**
31. **Boston Cream Pie**
32. Canned Pears
33. Baked Custard
34. Fresh Pineapple
35. Grapefruit Juice
36. **Bread**

December 21

1. **Half Grapefruit**
2. Orange Juice
3. **Crisp Corn Cereal or Rolled Wheat**
4. **Scrambled Egg**
5. Crisp Bacon
6. **Toast**

7. **Mushroom Bouillon**
8. **Saltines**
9. **Curried Pork Chops***
10. Roast Beef
11. **Fluffy Rice**
12. Fluffy Rice
13. **Diced Celery with Pimiento**
14. Quartered Carrots
15. **Stuffed Prune Salad**
16. **Maraschino French Dressing**
17. **Pineapple-Cherry Upside-Down Sponge Cake**
18. Sponge Cake Cubes, Custard Sauce
19. Raspberry Rennet-Custard
20. Unsweetened Plums
21. Apple Juice

22. **Corn Chowder**
23. **Oyster Crackers**
24. **Baked Stuffed Cabbage with Rice and Meat with Savory Tomato Sauce**
25. Meat, Rice and Tomato Puree
26. Broiled Veal Chop
27. Rice with Tomato Puree
28. **Julienne Green Beans**
29. **Banana Salad**
30. **Cream Mayonnaise**
31. **Chocolate Chip Ice Cream**
32. Grapefruit Sections
33. Chocolate Chip Ice Cream
34. Diced Orange and Grape Cup
35. Blended Juice
36. **Cornmeal Rolls**

December 22

1. **Fresh Grapes**
2. Apricot Nectar
3. **Oatmeal or Wheat Flakes**
4. **Soft Cooked Egg**
5. Crisp Bacon
6. **Toast**

7. **Hot Tomato Juice**
8. **Crisp Crackers**
9. **Fried Oysters—Tartar Sauce**
10. Broiled Cod Fillets
11. **Scalloped Potatoes**

12. Latticed Potatoes
13. **Whole Kernel Corn**
14. Asparagus Tips
15. **Cole Slaw**
16. ———
17. **Blueberry Pie**
18. Cottage Pudding, Chocolate Sauce
19. Coffee Rennet-Custard
20. Fresh Fruit Cup
21. Mixed Fruit Juice

———

22. **Cream of Celery Soup**
23. **Saltines**
24. **Fruit Salad Plate**
25. Omelet—Beets and Greens
26. Omelet—Beets and Greens
27. Baked Potatoes
28. ———
29. **Cottage Cheese on Lettuce**
30. ———
31. **White Cake with Peppermint Candy Icing**
32. Royal Anne Cherries
33. Cherry Gelatin
34. Fresh Apple
35. Pineapple Juice
36. **Bran Refrigerator Rolls**

December 23

1. **Tangerine**
2. Grapefruit Juice
3. **Shredded Wheat or Farina**
4. **Poached Egg**
5. Grilled Canadian Bacon
6. **Honey Buns**

———

7. **Beef Bouillon**
8. **Melba Toast**
9. **Roast Leg of Lamb—Currant Jelly**
10. Roast Leg of Lamb
11. **Potato Croquette**
12. Whipped Potatoes
13. **Frozen Baby Lima Beans**
14. Diced Straight-neck Squash
15. **Head Lettuce Salad**
16. **Fruited Honey Dressing**
17. **Fresh Pear and Orange Slices**
18. Grape Sponge
19. Grape Sponge
20. Fresh Pear and Orange Slices
21. Pineapple Juice

———

22. **Chilled Fruit Juice**
23. ———
24. **Chicken and Rice a la King Sauce**
25. Creamed Chicken
26. Sliced Chicken
27. Fluffy Rice
28. **Green Peas**
29. **Chef's Salad**
30. **Vinegar-Oil Dressing**
31. **Spice Cake with Lemon Icing***
32. Applesauce
33. Baked Custard
34. Unsweetened Applesauce
35. Consomme
36. **Crusty Hard Rolls**

December 24

1. **Orange Juice**
2. Orange Juice
3. **Granular Wheat Cereal or Puffed Wheat**
4. **Scrambled Egg** (Omit on General)
5. Crisp Bacon
6. **French Toast—Syrup**

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7. **Consomme**
8. **Crisp Crackers**
9. **Baked Smoked Ham**
10. Roast Veal Loin
11. **Glazed Yams**
12. Parslied Potatoes
13. **Chopped Spinach**
14. Julienne Beets
15. **Cabbage and Raisin Salad**
16. **Cream Mayonnaise**
17. **Fresh Pineapple Shortcake—Whipped Cream**
18. Canned Fruit Gelatin, Whipped Cream
19. Lemon Sherbet
20. Fresh Grapes
21. Grapeade

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22. **Green Split Pea Soup**
23. **Saltines**
24. **Egg Salad, Pimiento and Green Pepper Garnish—Stuffed Baked Potatoes**
25. Broiled Beef Pattie
26. Broiled Beef Pattie

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*Recipes may be obtained by writing to: HOSPITALS, Editorial Department, 18 E. Division Street, Chicago, 10.

27. Spaghetti with Tomato Puree
28. **Asparagus Tips**
29. **Carrot Sticks and Ripe Olives**
30. ———
31. **Ice Cream Coconut Snowballs, Holly Wreath Cookies**
32. Rice and Tinted Pear Compote
33. Vanilla Ice Cream
34. Fresh Fruit Cup
35. Mixed Fruit Juice
36. **Poppy Seed Rolls**

December 25

1. **Tangerine and Grapes**
2. Blended Juice
3. **Wheat and Barley Kernels or Hominy**
4. **Poached Egg**
5. Crisp Bacon
6. **Fruited Buns**

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7. **Tomato Bouillon**
8. **Crescent Rolls**
9. **Roast Turkey with Chestnut Dressing—Cranberry Sauce**
10. Roast Turkey
11. **Snowflake Potatoes**
12. Snowflake Potatoes
13. **Brussels Sprouts**
14. Mashed Hubbard Squash
15. **Santa Claus Salad**
16. ———
17. **Steamed Plum Pudding, Foamy Sauce**
18. Pale Green Meringue Baskets with Strawberry Ice Cream
19. Lime Sherbet
20. Fresh Strawberries and Pineapple
21. Apricot Nectar

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22. **Oyster Stew**
23. **Oyster Crackers**
24. **Grapefruit, Avocado, Pomegranate Seed Salad—Cream Cheese and Onion Finger Sandwiches**
25. Grapefruit and Avocado on Lettuce—Cottage Cheese
26. Grapefruit and Avocado Salad—Cottage Cheese
27. ———
28. ———
29. **Celery Curls**
30. ———
31. **Christmas Cookies and Fruit Cake**
32. Lime and Cherry Gelatin Cubes
33. Lime and Cherry Gelatin Cubes
34. Jonathan Apple
35. Orange Juice
36. ———

December 26

1. **Sliced Banana**
2. Apricot Nectar
3. **Rolled Wheat or Crisp Rice Cereal**
4. **Soft Cooked Egg**
5. Crisp Bacon
6. **Toast**

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7. **Consomme**
8. **Whole Wheat Wafers**
9. **Breaded Veal Cutlet**
10. Broiled Veal Steak
11. **Potatoes au Gratin**
12. Cubed Potatoes
13. **Stewed Tomatoes and Celery**
14. Green Peas
15. **Lettuce Wedge Salad**
16. **Russian Dressing**
17. **Butterscotch Pie**
18. Butterscotch Pudding
19. Raspberry Rennet-Custard
20. Unsweetened Apricots
21. Grapefruit Juice

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22. **Cranberry Juice**
23. ———
24. **Hot Turkey Sandwich or Turkey-Mushroom Scallop***
25. Sliced Turkey
26. Sliced Turkey
27. Baked Potatoes
28. **Sliced Young Zucchini**
29. **Orange and Red Apple Salad**
30. **French Dressing**
31. **Coconut Cup Cakes**
32. Banana Whip
33. Butterscotch Pudding
34. Unsweetened Plums
35. Beef Bouillon
36. ———

December 27

1. **Half Grapefruit**
2. Grapefruit Juice
3. **Corn Flakes or Scotch Bran Brose**
4. **Baked Egg**
5. Crisp Bacon
6. **Toast**

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7. **Mushroom Bouillon**
8. **Saltines**
9. **Roast Beef**
10. Roast Beef
11. **Parslied Potatoes**
12. Parslied Potatoes
13. **Mashed Rutabagas**
14. Green Beans
15. **Beet and Cabbage Relish**
16. ———
17. **Mincemeat Turnovers**
18. Orange Sections with Custard
19. Strawberry Gelatin
20. Orange Slices
21. Pineapple Juice

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22. **Turkey Broth with Rice**
23. **Crisp Crackers**
24. **Creamed Ham and Eggs in Noodle Ring**
25. Scrambled Eggs and Noodles
26. Broiled Lamb Chop
27. Noodles
28. **Spinach with Lemon**
29. **Tangerine and Grape Salad**
30. **French Dressing**
31. **Lemon Sherbet—Crisp Chocolate Cookies**
32. Lemon Sherbet
33. Lemon Sherbet
34. Unsweetened Cherries
35. Tomato Juice
36. **Oatmeal Bread**

December 28

1. **Tomato Juice**
2. Tomato Juice
3. **Farina or Raisin Bran Flakes**
4. **Poached Egg**
5. Grilled Ham
6. **Cornmeal Muffins**

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7. **Beef Broth**
8. **Crisp Crackers**
9. **Country Style Liver—French Fried Onion Rings**
10. Broiled Liver
11. **Scalloped Potatoes**
12. Baked Potatoes
13. **Whole Kernel Corn**
14. New Beets and Greens
15. **Celery Curls—Gherkins**
16. ———
17. **Strawberry Sundae**
18. Vanilla Ice Cream
19. Orange Sherbet
20. Fresh Fruit Cup
21. Cherry Nectar

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22. **French Onion Soup**
23. **Cheese Rye Croutons**
24. **Round Steak Birds, Gravy—Brown Rice**
25. Minced Beef
26. Broiled Beef Pattie
27. Potato Balls
28. **Carrot Balls**
29. **Mixed Green Salad**
30. **Herb French Dressing**
31. **Canned Plums—Corn Finke Meringues**
32. Applesauce
33. Vanilla Ice Cream
34. Unsweetened Applesauce
35. Orange Juice
36. **Bread**

December 29

1. **Sliced Orange**
2. Blended Juice
3. **Puffed Rice or Granular Wheat Cereal**
4. **Scrambled Egg**
5. Crisp Bacon
6. **Hot Biscuits**

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7. **Hot Vegetable Juice**
8. **Saltines**
9. **Shrimp and Crabmeat Casserole**
10. Broiled Halibut
11. **Stuffed Baked Potatoes**
12. Steamed Potatoes
13. **Frozen Baby Lima Beans**
14. Patty-Pan Squash
15. **Hearts of Lettuce**
16. **Parisian French Dressing**
17. **Steamed Cranberry Pudding**
18. Strawberry Bavarian
19. Cherry Gelatin
20. Unsweetened Plums
21. Grapefruit Juice

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22. **French Tomato Soup**
23. **Melba Toast**
24. **Tuna Salad Sandwich—Potato Chips—Radishes**
25. Creamed Tuna—Green Beans
26. Broiled Flounder—Green Beans
27. Baked Potatoes
28. ———
29. **Head Lettuce Salad**
30. **Thousand Island Dressing**
31. **Canned Peach, Whipped Cream and Walnuts**
32. Canned Peaches
33. Baked Custard
34. Unsweetened Peaches
35. Mixed Fruit Juice
36. ———

December 30

1. **Sliced Banana**
2. Grapefruit Juice
3. **Oatmeal or Crisp Corn Cereal**
4. **Soft Cooked Egg**
5. Crisp Bacon
6. **Toast**

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7. **Consomme**
8. **Crisp Crackers**
9. **Baked Canadian Bacon, Fruit Sauce**
10. Roast Leg of Lamb
11. **Mashed Potatoes**
12. Riced Potatoes
13. **Asparagus Tips**
14. Sliced Carrots
15. **Pineapple, Cabbage and Coconut Salad**
16. ———
17. **Crunchy-Top Gingerbread**
18. Pink Grapefruit Sections
19. Chocolate Rennet-Custard
20. Pink Grapefruit Sections
21. Apricot Nectar

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22. **Potage Longchamps**
23. **Croutons**
24. **Veal Timbale, Mushroom Sauce**
25. Veal Timbale
26. Broiled Veal Chop
27. Baked Yams
28. **Green Peas**
29. **Orange—Endive Salad**
30. **Poppyseed Dressing**
31. **Rebecca Pudding, Bing Cherry Sauce**
32. Rebecca Pudding, Cherry Sauce
33. Soft Custard
34. Fresh Pear
35. Pineapple Juice
36. **Cornsticks—Apple Jelly**

December 31

1. **Half Grapefruit**
2. Apricot Nectar
3. **Wheat Flakes or Hominy**
4. **Poached Egg**
5. Link Sausage
6. **Toast**

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7. **Beef Bouillon**
8. **Toasted Crusts**
9. **Chicken Fricassee with Parsley Dumplings**
10. Roast Chicken
11. **Grilled Sweet Potatoes**
12. Fluffy Rice
13. **Broccoli**
14. Sliced Beets
15. **Jellied Fruit Salad**
16. **Cream Mayonnaise**
17. **Cranberry Sherbet**
18. Cranberry Sherbet
19. Cranberry Sherbet
20. Fresh Pineapple
21. Orange Juice

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22. **Tomato Juice**
23. ———
24. **Braised Beef with Noodles**
25. Hot Beef Cubes—Squash Rings
26. Hot Beef Cubes—Squash Rings
27. Noodles
28. ———
29. **Raw Vegetable Salad Bowl**
30. **Italian French Dressing**
31. **Baked Apples—Whipped Lemon Topping**
32. Applesauce
33. Lemon Rennet-Custard
34. Unsweetened Apricots
35. Consomme
36. **Pumpernickel Bread**

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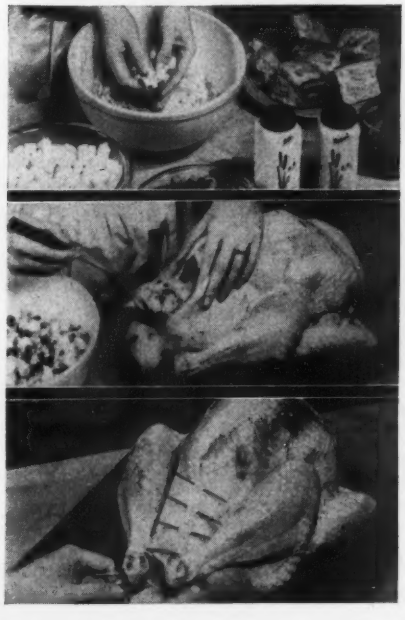

This dressing is equally delicious baked in a separate pan.

CORN BREAD DRESSING

Dressing
For 4 twelve lb. turkeys

Total Weight of Dressing: 13 lb. 12 oz.

INGREDIENTS	AMOUNT	WEIGHT	COST
Corn Bread, crumbled*	6 quarts	5 lb. 5 oz.	
Soft Bread Crumbs	6 quarts	1 lb. 12 oz.	
Salt	2½ tablespoons		
Pepper	2 teaspoons		
Poultry Seasoning	2 tablespoons		
Butter or Margarine	1½ cups	12 oz.	
Shortening or Drippings	2 cups	12 oz.	
Nutmeats, chopped	3 cups	1 lb.	
Celery, diced	1½ quarts	1 lb. 12 oz.	
Onion, chopped	2 cups	10 oz.	
Green Pepper, chopped	2 cups	10 oz.	
Eggs, beaten	6 eggs	10½ oz. (E.P.)	
Water	about 3 cups		

Directions

1. Combine crumbled corn bread and bread crumbs. Sprinkle with seasonings.
2. Brown nutmeats in shortening. Add celery and onion and cook until softened. Add to corn bread mixture. Stir in the green pepper.
3. Fold in the beaten eggs and 2 cups of the water. Add remaining water gradually until dressing is of desired moistness.
4. Stuff lightly into body cavity and neck region of turkeys or other fowl.

* *See Golden Corn Muffin recipe (bake as corn bread).*

CORN BREAD DRESSING — THE QUAKER OATS COMPANY INSTITUTIONAL KITCHEN

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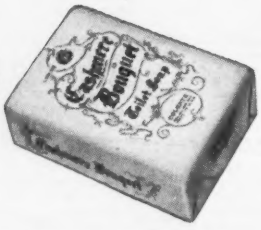

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PERSONAL *News*

DR. WILLIAM SCHILLING, clinical director of Warren (Pa.) State Hospital, has been appointed superintendent of Torrance (Pa.) State Hospital.

He succeeds DR. JOHN I. WISEMAN, who retired October 15. Dr. Wiseman had been associated with the Torrance State Hospital for the past 20 years.

DR. ROBERT R. CADMUS became director of the new teaching hospital at the University of North Carolina, Chapel Hill, on September 1. He has been serving that university in a consulting capacity since May 1950.

In 1942, Dr. Cadmus entered the U.S. Army as a first lieutenant. He was discharged in October 1945, having achieved the rank of lieutenant colonel.

Dr. Cadmus was director of the Vanderbilt Clinic of Presbyterian Hospital in the City of New York for three years. Since 1948, he has been assistant director of the University Hospitals of Cleveland.

DR. FREDERICK BECK has become director of Ray Brook (N.Y.) State Tuberculosis Hospital. He succeeded DR. HARRY A. BRAY, who has retired after 43 years' association with that hospital.

For the past five years, Dr. Beck was assistant director of Hermann M. Biggs Memorial Hospital, Ithaca, N.Y.

MARY L. MARGERUM, superintendent of Greenfield (Ohio) Municipal Hospital since 1947, has resigned. She has been replaced by FERN DOSTER who was named acting superintendent.

MAURICE P. PACKWOOD became superintendent of Hamilton County Home and Chronic Disease Hospital, Cincinnati, on September 16.

He succeeds C. H. BRUNEMANN, who has been acting superintendent of Hamilton County Home and Chronic Disease Hospital since October 1949.

For 13 years, Mr. Packwood was assistant director of Cleveland (Ohio) City Hospital. From 1944 to 1946, he was chief medical and sanitation supply officer of the United Nations Relief and Rehabilitation Administration, with headquarters at Cairo, Egypt. Mr. Packwood has been business manager of the Cincinnati (Ohio) General Hospital for the past three and one-half years.

DR. FRED W. ROUTLEY has been awarded the Cross of Chevalier de la Legion d'Honneur by the French Government. The award was made for Dr. Routley's work as the former National commissioner of the Canadian Red Cross. At the present time, Dr. Routley is secretary of the Ontario Hospital Association.

WALTER J. ROME has been named superintendent of Children's Hospital of Pittsburgh. He replaces PHILIP H. LANTZ, who has retired after 12 years with that hospital.

JOHN L. BECKWITH, assistant administrator of Highland Hospital, Rochester, N.Y., was commissioned

a first lieutenant in the Medical Service Corps of the United States Air Force Reserve. Brig. Gen. Edward J. Kendricks, director of staffing and education, Office of the Surgeon General, U.S.A.F., administered the oath (above).

Lieutenant Beckwith received a master's degree in hospital administration from the University of Minnesota, Minneapolis, in June 1950. He served his administrative residency at Syracuse (N.Y.) Memorial Hospital.

DR. HERBERT T. WAGNER has succeeded CATHERINE M. MALOY as director of hospital services for the National Foundation for Infantile Paralysis, New York City.

Dr. Wagner went to the National Foundation from the Utah State Hospital for Poliomyelitis and Other Crippling Children's Diseases, Salt Lake City. He had served as medical director and superintendent there from January 1949 to June 1950. Dr. Wagner previously has been assistant director of Roosevelt Hospital, New York City, and director of Meriden (Conn.) Hospital.

DR. EUGENE D. ROSENFELD will become executive director of the new Long Island Jewish Hospital, New York City, on or about January 1, 1951. Prior to this appointment, Dr. Rosenfeld was assistant director of Montefiore Hospital, New York City.

RALPH R. HOBART has been appointed administrator of the Coffeyville (Kans.) Memorial Hospital. He succeeds ALMA I. SCHIEK, R.N., who served as administrator of that institution since May 1949.

For the past year, Mr. Hobart has been administrator of Ransom Memorial Hospital, Ottawa, Kans., and prior to that was assistant administrator at the Iowa Methodist Hospital, Des Moines.

HAROLD A. SAYLES, administrator of Harris Hospital, Fort Worth, since March 1949, resigned on October 1. The REV. W. W. WARD has been named acting administrator of that institution.

Mr. Sayles previously served as superintendent of Marion Sims Memorial Hospital, Lancaster, S.C.,

and Pontiac (Mich.) General Hospital.

ROBERT GUY became administrator of the Baton Rouge (La.) General Hospital on October 17. Prior to this appointment, Mr. Guy served at the Georgia Baptist Hospital, Atlanta.

ROBERT B. JARVIS has been appointed superintendent of Lock Haven (Pa.) Hospital. He replaces ADA C. ZORGER, who has been acting manager of that institution since October 1949.

Before going to Lock Haven, Mr. Jarvis was superintendent of Potter County Memorial Hospital, Coudersport, Pa.

DR. EDWARD J. JOHNSON has become superintendent of Tacoma (Wash.) Indian Hospital. He has served at that institution for the past three years and has been acting superintendent and medical officer there since July 1949.

THOMAS B. SELLERS, JR., assistant director of Hermann Hospital, Houston, has been appointed administrator of Southern Pacific Hospital, Houston. In going to Southern Pacific Hospital, he replaces ROY WILMESMEIER who has become director of hospital relations for the Group Hospital Service, Texas' Blue Cross plan.

LEONARD W. DAYS resigned as assistant manager of the Veterans Administration Hospital at Bedford, Mass., to become superintendent of the Pasadena (Calif.) Dispensary.

Mr. Days formerly was chief of Veterans Administration Hospitalization section, Washington, D.C. During World War II, he served as a major in the Army Medical Administrative Corps. Before entering the service, Mr. Days studied for his master's degree in hospital administration at the University of Chicago. Prior to that time, he was associated with Massachusetts General Hospital for 11 years.

DR. HAROLD H. CASHMAN has succeeded DR. W. MILES GARRISON as medical superintendent of Belmont Sanatorium, St. Clairsville, Ohio. Dr. Garrison is retiring after serving 23 years as superintendent of that institution.

EUGENE R. ANDRES resigned as administrator of Midland (Texas) Memorial Hospital on October 1. He had served at that institution since 1948 and, prior to that, was superintendent of Methodist State Hospital, Mitchell, S.D.

JOHN H. BLAKE, administrator of Wabash (Ind.) County Hospital, has been recalled to military service. Previously, Mr. Blake served as assistant administrator of the Women's and Children's Hospital, Chicago, and DuPage County Hospital, Elmhurst, Ill.

WERNER P. GEIGENMULLER became assistant superintendent of Stanford University Hospitals, San Francisco, on August 1. He was assistant to the superintendent for the past four and a half years.

Mr. Geigenmuller has been associated with the hospital field for 15 years, having been connected with Franklin and Mount Zion Hospitals, San Francisco, before going to Stanford University Hospitals. During World War II, he served in the Army Medical Corps. for three years.

HAROLD G. SYPTAK has succeeded LYNN IRVING as administrator and technician of Goliad (Texas) County Memorial Hospital. Prior to this appointment, Mr. Syptak was associated with Brooke General Hospital, Fort Sam Houston, and Baptist Memorial Hospital, San Antonio.

MARY ANNE HUGO, R.N., has been named director of nurses and school of nursing at Montana Deaconess Hospital, Great Falls.

Miss Hugo formerly served as director of nurses and schools of nursing in New York, New Jersey and Hawaii.

WILLIAM L. AGRESS, formerly an official of the Brooklyn Tuberculosis and Health Association and of the New York State Department of Health, has been appointed assistant director of Mount Sinai Hospital in New York City.

Mr. Agress recently completed a year's study at Mount Sinai Hospital under the S. S. Goldwater fellowship in hospital administration. During World War II, he was a medical instructor and sanitation officer of the Sheepshead Bay Training Station of the U. S. Maritime Service.

GEORGE PECK has resigned as administrator of Jewish Hospital, Philadelphia, and has become associated with the convention bureau of the Hotel Traymore, Atlantic City.

JOHN E. PAPLOW has succeeded GLADYS SMITS as administrator of Santa Barbara (Calif.) Cottage Hospital. He previously was assistant administrator of that institution.

WILLIAM A. DAWSON has resigned as superintendent of Good Samaritan Hospital, Lebanon, Pa., to become administrator of the new Bedford (Pa.) County Memorial Hospital. A member of the American College of Hospital Administrators, Mr. Dawson formerly served as administrator of South Baltimore General Hospital, Baltimore, Md.

He was succeeded at Good Samaritan Hospital by ELEANOR HAROLD, R.N., who had been director of nurses.

The following appointments were announced recently by the Veterans Administration:

DR. HENRY A. DAVIDSON has been appointed chief of psychiatry for the nine states in the Washington, D.C., Area Medical Office with headquarters in the Veterans Administration Washington Regional Office.

NOEL M. JEFFREY succeeded DR. E. H. H. FOSTER as manager of the Veterans Administration Hospital, Vancouver, Wash., October 1. Dr.

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WALL-MOUNTED *auxiliary* BUCKY STAND

Foster has retired from government service.

Mr. Jeffrey previously was manager of the Veterans Administration Hospital at Castle Point, N.Y. He has been replaced there by FRANK W. CLAYTON, assistant manager of the Veterans Administration Hospital, Bronx, N.Y.

CLAIRE BOWMAN, R.N., has been appointed director of nursing service and education at Wyoming County Community Hospital, Warsaw, N.Y.

Miss Bowman became assistant director of nursing at Sibley Memorial Hospital, Washington, D.C., in 1946. Three years later, she entered a year's postgraduate study in the field of nursing education at Columbia University, New York City.

Miss Bowman has held administrative and nursing positions at St. Luke's Hospital, New York City, and at hospitals in Carbondale, Pa., and Berwick, Pa.

JOHN A. MOBERLY, administrator of Clearfield (Pa.) Hospital, has been named administrator of Memorial Hospital, Cumberland, Md.

In going to Memorial Hospital, Mr. Moberly replaces BENJAMIN W. WRIGHT, who now is director of Wilmington (Del.) General Hospital.

DR. O. E. STEVENSON, superintendent of the State Hospital for Epileptics, Parsons, Kans., for the past three years, has resigned. JOHN W. PRATT, business manager at that institution, has been named acting superintendent.

ORVILLE F. CRAIG has become administrator of Safford (Ariz.) Inn and Hospital, which opened September 15. Prior to this appointment, Mr. Craig was administrator of Hatch (N. Mex.) General Hospital.

SISTER MARY IMELDA has succeeded SISTER M. LOYOLA, R.N., as superintendent of St. James Hospital, Newark, N.J.

Deaths

H. LEE MASON JR. died at Pittsburgh, Pa., on September 7. He had served as director of the Allegheny General Hospital, Pittsburgh, since 1917 and as president of its board since 1946. Mr. Mason was an honorary life member of the American Hospital Association.

DR. WALTER WOOD KING, a retired medical director in the United States Public Health Service, died on October 9 at Baltimore.

Dr. King had been with the Public Health Service for more than three decades.

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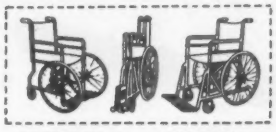

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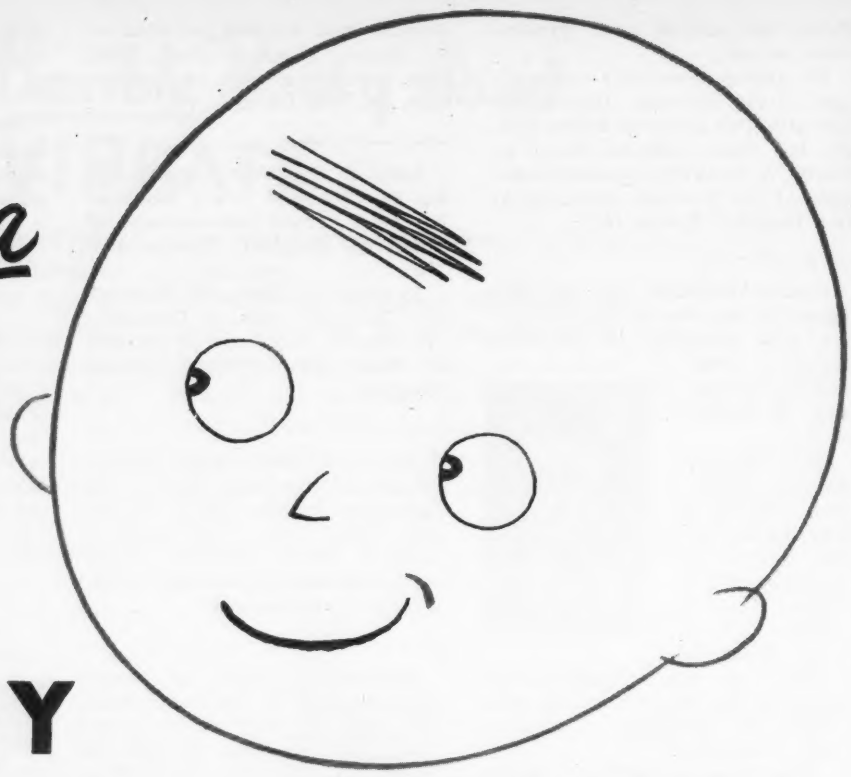

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Ivory is superbly pure and mild. Its rich lather cleanses the skin gently and thoroughly. It has no strong perfume. It is equally pleasing for patient use and for hospital personnel. *And Ivory costs surprisingly little for a soap of such recognized fineness.*

No other soap can give you more honest value for your soap dollars. This fact is confirmed by the many, many fine hospitals which have consistently used Ivory during the past half century.

Ivory Soap is available for hospital use in the popular unwrapped 3-ounce size, as well as in smaller sizes—wrapped or unwrapped.

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MORE DOCTORS ADVISE IVORY SOAP THAN ALL OTHER BRANDS TOGETHER!

Films available to hospitals

(Continued from page 71)

Purchase prints from General Motors Corp., $15 (film agreement required).

Lemuel Q. Stoopnagel, the word-twisting and thought-twisting comedian of stage, screen and radio, burlesques the common errors and omissions so frequently encountered in poorly-planned meetings.

This picture is not intended to show parliamentary procedure, or to depict all the rules for conducting a meeting. Rather it is a comedy treatment of certain types of informal luncheon gatherings and shows the way not to conduct a meeting.

Typical faults included are:

Poor acoustics.

Poor ventilation.

Interruptions.

Inadequate planning.

The film is intended as a satire on the manner in which some poorly planned meetings are conducted.

Especially good for local, state and individual hospital meetings.

A New Supervisor Takes a Look at His Job

(16mm, black and white, sound, 13 min.)

Produced by U. S. Office of Education.

Rental: Association Films, Inc., 206 So. Michigan Ave., Chicago 3. $2.

Purchase print: United World Films, Inc., 1445 Park Ave., New York City 29. $23.60.

A young workman has just been made a line supervisor. In the interview with the superintendent, he is shown that in his new job he must learn to get results from people instead of machines.

For supervisory training; industry again, but application of principles can be made in hospitals.

Working With Other Supervisors

(16mm, black and white, sound, 8 min.)

Produced by the U. S. Office of Education.

Rental: Association Films, Inc., 206 So. Michigan Ave., Chicago 3. $1.

Purchase prints: United World Films, Inc., 1445 Park Avenue, New York City 29. $17.88.

Several supervisors discuss Larry, one of their colleagues, who has been unable to work harmoniously with them. The question is raised—What can be done about Larry?

Good for starting discussion on functions of supervision.

Supervisor as a Leader, Parts 1 and 2

(16mm, black and white, sound, part 1—14 min., part 2—13 min.)

Produced by U. S. Office of Education.

Rental: Association Films, Inc., 206 So. Michigan Ave., Chicago 3. $1.

Purchase prints: United World Films, Inc., 1445 Park Avenue, New York City 29. Part 1—$25.71; part 2—$23.60.

Part 1—Several workmen are asked what they consider to be the qualifications of a good supervisor: Always keep promises. Never take credit for someone else's work. Don't pass the buck. Don't play favorites.

Part 2—Four supervisors discuss the qualities of leadership. Dramatized incidents make clear what they mean. One man lets his job go to his head. Another goes to pieces under pressure, he can't control himself. In other incidents, it is pointed out that the good supervisor is not afraid to praise his men for work well done and that he is loyal to them.

Orientation for supervisors and as a stimulus to group discussion of supervisory problems.

Supervising Workers on the Job

(16mm, black and white, sound, 10 min.)

Produced by U. S. Office of Education.

Loan: Association Films, Inc., 206 So. Michigan Ave., Chicago 3. $2.

Purchase print: United World Films, Inc., 1445 Park Ave., New York City 29. $20.74.

Various kinds of poor supervision practices are shown, among them, nagging and snooping. By dramatized incidents, the poor results of these methods are made apparent.

For supervisory training; factory application, but principles are the same for any employee-supervisor relationship.

It's Up to You

(16 mm, black and white, sound, 24 min.)

Produced for Associated Merchandise Corporation.

Loan or rent from stores which are members of the Associated Merchandise Corporation and have purchased prints.

Purchase prints: Caravel Films, 730 Fifth Ave., New York City.

Store supervision. Supervisor does all the wrong things, antagonizes people and makes more work for himself; then he sees errors of his ways.

Good for training supervisors: how to get along with people.

Introducing the New Worker to His Job

(16mm, black and white, sound, 16 min.)

Produced by the U. S. Office of Education.

Rental: Association Films, Inc., 206 So. Michigan Ave., Chicago 3. $1.

Purchase prints: United World Films, Inc., 1445 Park Avenue, New York City 29. $27.88.

A new worker is being started on his job. First, the induction is done very poorly. Then, the same job is done over again, but this time as it should be. The difference between the first and second ways of inducting the worker is obvious.

Direct factory application in employee training, but principles good. Orientation is the same in any management situation.

First Impressions

(16 mm, black and white, sound, 21 min.)

Produced by U. S. Navy.

Rental: Association Films, 206 So. Michigan Ave., Chicago 3. $3.

Purchase prints: United World Films, Inc., 1445 Park Ave., New York City 29. $27.12.

Discusses reasons why new employees may not like their jobs and gives some primary steps in giving them a good first impression of their work.

Navy civilian office in wartime, but factors in proper orientation of new employees in any office are well illustrated. Primarily for supervisory personnel.

The Boss Didn't Say "Good Morning"

(16mm, black and white, sound, 12 min.)

Rental: Association Films, Inc., 206 So. Michigan Ave., Chicago 3. $1.

Shows importance to employee's well-being and sense of security of the boss's greeting. When he doesn't speak, it's human nature to imagine you've done something wrong, that your job is in jeopardy.

Would be fine for starting a discussion in a meeting of department heads.

Every Minute Counts

(16mm, black and white, sound, 10 min.)

Produced by U. S. Office of Education.

Rental: Association Films, Inc., 206 So. Michigan Ave., Chicago 3. $1.

Purchase prints: United World Films, Inc., 1445 Park Ave., New York City 29. $20.74.

A supervisor becomes worried because of absenteeism and tardiness in his department. His superintendent points out many of the causes, and the supervisor takes steps to remedy them.

For supervisory training. Another good film for showing in department head meetings.

NEWS

· · FEDERAL, LEGISLATIVE · ·

Action on Hill-Burton Up to Congress

Congress returns to Washington November 27 for what was planned to be a short, almost routine, session at which very little major business would be transacted. However, the budget bureau's drastic 50 per cent reduction of Hill-Burton hospital construction grants for this fiscal year has aroused such a storm of protest that the chances are at least even that special legislation will be enacted restoring all or part of the $75,000,000 which was slashed from the grant-in-aid pool.

If restitution is not made before the end of 1950, it is felt by Washington observers that such action will be taken early next year by the new 82nd Congress. Acceleration of the country's civil defense program will give impetus to efforts to restore Hill-Burton expansion to full authorized strength, since it is obvious that hospitals and their facilities are indispensable to community defense planning.

Regarding the Hill-Burton retrenchment, the budget bureau's action accentuated its policy differences with the hospital facilities division of Public Health Service, which administers the law. The former holds that federal obligations to hospital-construction sponsors do not exist, as far as commitment of grants is concerned, until projects receive final approval in Washington. On the other hand, the Public Health Service feels that it has a moral responsibility to follow through from the time that initial approval is given and local communities have begun to raise matching funds in anticipation of government assistance.

"Out of the $150,000,000 provided in the General Appropriation Act for hospital construction grants, $75,000,000 has been placed in reserve," Budget Director Frederick J. Lawton explained. "The remaining $75,000,000, together with $92,000,000 still available from 1950 funds, makes a total of $167,000,000 available during the 1951 fiscal year, compared to obligations for the 1950 fiscal year of $118,000,000.

"The savings will limit the number of new hospital projects which can be accepted during the 1951 fiscal year but will not necessitate delay or cancellation of any projects which already have received final approval of the surgeon general of the Public Health Service. Authority is vested in the states, rather than in the federal government, to decide which individual projects shall go forward."

Two Interpretations

This is the gist of the reply which the White House, in recent weeks, has sent to members of Congress, governors of states and others who have protested halving of Hill-Burton grant funds for the present fiscal year. But its premise is rejected—though not openly—by the Public Health Service, whose feeling is that sponsors of projects which have received initial approval are entitled to consideration no less than those whose enterprises have received final approval.

Douglas N. West, of the hospital facilities division, visited a number of state agencies in October to ascertain ways and means of achieving the mandatory retrenchment with a minimum of hardship and inconvenience.

Whether the cutback ultimately will be rescinded and the hospital construction program allowed to proceed without abridgment may depend largely on future recommendations of the office of health resources, National Security Resources Board. In this connection, the latest addition to the unit's professional staff is Dr. David B. Wilson, formerly assistant medical director of Alameda County (California) health institutions under Dr. G. Otis Whitecotton, director, and at one time on the staff of the hospital facilities division, Public Health Service.

Dr. Wilson's duties will be concerned exclusively with national hospital problems.

OFFICERS of the Inter-American Hospital Association met with Dr. Fred L. Soper, director of Pan American Sanitary Bureau, regional office for the Americas of the World Health Organization, during September to discuss joint programs for hospital activities sponsored by the two groups. Seated (left to right) are: Vice president, James Hamilton, University of Minnesota; Dr. Soper, and president, Dr. Guillermo Almenara, Peru. Standing (from left) are: Executive director of the association, Felix Lamela, hospital section, Pan American Sanitary Bureau; treasurer, Fred A. McNamara, U. S. Bureau of the Budget, and Dr. Odair Pedroso, Brazil regional director of the inter-American association.

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COURTESY, KENTUCKY STATE MEDICAL ASSOCIATION

Ephraim McDowell

1771-1830

On December 13, 1809, Dr. Ephraim McDowell performed the operation in Danville, Ky., which earned him the title "The Father of Ovariotomy," when he removed fifteen pounds of ovarian tumor from a woman patient. The first operation of its kind was performed at his home while horrified, enraged citizens surrounded the house, prepared to hang the doctor. However, the townspeople who came to kill remained to cheer; his patient lived to be 80, and Dr. McDowell became world-famous for his surgical skill and pioneer courage.

Ephraim McDowell was born in Rockbridge County, Va., November 11, 1771. He attended a classical school at Georgetown, Va.; studied medicine under Dr. Humphreys, of Staunton, Va., and at the University of Edinburgh, Scotland, in 1793 and 1794. In 1795 he started to practice medicine and surgery in Danville.

Dr. McDowell was elected a member of the Medical Society of Philadelphia in 1817; was one of the founders and an original trustee of Center College, Danville, Ky., 1819-1823. He died in Danville on June 20, 1830. A marble monument was erected to his memory in McDowell Park, Danville, by the State medical society, in 1879, and in 1929 he was further honored by his native state when his statue was unveiled in Statuary Hall, United States Capitol, Washington, D. C., presented by the State of Kentucky.

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Surgiset contains an extra jar for storing your other sutures.

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Doctor-Draft Law

Another problem confronting the nation's hospitals is tied up with the doctor-draft law, which is now beginning to take effect. Particularly concerned are teaching and residency-training institutions, with federal officials estimating that nearly three-fourths of the younger physicians subject to early draft call are presently engaged in hospital residencies.

Selective service spokesmen have indicated definitely that it will be extremely difficult to gain deferment of any hospital residents. The Veterans Administration, which employs 2,700 physicians in this category, already has announced that it will not seek deferment of any of them. Deferment policies are mainly in the hands of the selective service medical advisory committee headed by Dr. Howard A. Rusk. Its members comprise, without exception, the members of National Security Resources Board's health resources advisory group. That President Truman would appoint the NSRB unit to perform double-duty as Maj. Gen. Lewis B. Hershey's medical advisory staff was forecast in the October issue of HOSPITALS.

However, David M. Heyman, chairman of the board of the Health Insurance Plan of Greater New York, no longer is a member of the NSRB advisers. His resignation came about as a result of the White House decision to have the same group serve both Selective Service and NSRB. Inasmuch as the doctor-draft law requires that none but professional members of the medical and health sciences shall be appointed to the new selective service advisory body, Mr. Heyman resigned so that the dual-service plan could be effectuated.

Directory of Projects

Early in November, the hospital facilities division, Public Health Service, is scheduled to publish a comprehensive directory of Hill-Burton projects.

As of August 31, latest date for which figures are available, 1,476 Hill-Burton projects were on the books, of which 243 were completed and in operation, 808 under construction and the remaining 425 in preliminary stages of planning. Estimated total cost of all 1,476 was $1,016,700,543. Federal share was $374,759,783. Full execution of this program would add 71,821 beds and 265 health centers.

· FEDERAL, ADMINISTRATIVE ·

Court Dismisses Portland Case

On an important governmental front, namely, prosecution of anti-trust cases against medical groups by the Department of Justice, the government is expected to decide in November whether it will appeal to the Supreme Court from an adverse court decision in Portland, Ore. In that case, Federal Judge Claude McColloch held that the Department of Justice failed to prove its charges of monopolistic conspiracy against the Oregon State Medical Society, Oregon Physicians Service or any of the other defendants. (For background information on the Oregon case, see page 132, of HOSPITALS for September.)

Judge McColloch, in his statement of opinion preceding issuance of a judgment of dismissal, said in part:

"A striking instance of local initiative is furnished by the Klamath County doctors. At a cost to themselves of $400,000, the Klamath doctors purchased and modernized two privately owned hospitals. They did this because hospital costs were too high under private management and the service was not adequate.

"Needless to say, after this heavy investment, the Klamath doctors have their own local prepaid plan and for this, although not named as defendants, they are charged with being parties to the alleged state-wide conspiracy to restrict medical care.

"I have great difficulty in following the government's criticism of county and regional doctor groups who have set up their own local prepaid plans. They are but discharging their duty to their own local people, it seems to me.

"Is this what the government wants, that doctors should leave the field to the privately owned companies? Certainly not that, for at the trial the government lawyers conceded the right to the doctors to compete."

The court held that the defendants did not boycott privately owned hospital associations and that Oregon Physicians Service "is not a conspiracy but, rather, an entirely legal and legitimate effort by the profession to meet the demands of the times for broadened medical and hospital service, eliminating the evils of privately owned concerns as well as the element of private profit."

The government's defeat in the Oregon case, issues of which were similar to those involved in its successful prosecution of the American Medical Association in 1941, has raised doubt whether the Department of Justice will launch court proceedings in Ohio, Illinois and other states where medical society records have undergone FBI scrutiny during the past year. Even if an appeal is carried to the Supreme Court, it is questionable whether a decision by that tribunal would be handed down before its annual May recess.

First to Sign Up

1st Lt. Agnes Juanita Ratcliff, a dietitian at Walter Reed Hospital, Washington, D. C., was the first Women's Medical Specialist Corps member to receive a commission in the regular army under the new program authorized by Public Law 514. The program opens regular army commissions to certain World War II nurses and WMSC officers previously ineligible because of age.

There is an immediate need for 70 dietitians, 40 physical therapists and 65 occupational therapists in

SHOWN congratulating 1st Lt. Agnes Ratcliff (at left) is Maj. Gen. Paul H. Streit.

DR. JOHN W. CRONIN and Dr. R. C. Williams of the Public Health Service and Robert Fischelis of the American Pharmaceutical Association inspect a scale model of a hospital pharmacy built to specifications outlined in the new elements of the hospital pharmacy. These Public Health Service elements were described in the October issue of HOSPITALS.

the Women's Medical Specialist Corps. Col. Emma E. Vogel is chief of the organization.

Navy Examines Deaths

A statistical report by the bureau of medicine and surgery, navy department, discloses that postmortem examinations were performed on 40 per cent of the 966 deaths occurring among active duty navy and marine corps personnel in 1949. Accidental injuries accounted for 750 of the fatalities, 27 were due to poisoning, and 189 resulted from diseases. In the last named category, 58 deaths were attributed to malignancies and other neoplastic conditions, which held No. 1 rating as a mortality factor. Next in order were diseases of the circulatory system (50) and gastrointestinal conditions (19). Fifty of the 58 neoplastic deaths (86 per cent) went to postmortem examination.

Dr. Soper Re-elected

The 13th Pan American Sanitary Conference, meeting early last month in Ciudad Trujillo, capital of the Dominican Republic, re-elected Dr. Fred L. Soper to a second four-year term as director of the Pan American Sanitary Bureau, Washington, D. C. His new term of office will begin on Feb. 1, 1951.

Dr. Soper reported to the conference on the activities of the bureau. One of the more outstanding developments during the past four years has been the campaign against the yellow fever carrying mosquito which has resulted in eliminating the mosquito from several countries in the hemisphere.

Conference chairman was Dr. Manuel A. Robiou, Dominican secretary of state of health and public assistance.

Heads Health Institutes

Dr. William H. Sebrell is the new director of the National Institutes of Health in Bethesda, Md., succeeding Dr. Rolla E. Dyer who retired the first of October. Institutes have been established by the Public Health Service to study cancer, heart disease, mental disease, rheumatism, arthritis, metabolic and neurological diseases, and blindness.

Since the formation of the Experimental Biology and Medicine Institute in 1948, Dr. Sebrell has directed its activities. Before that he headed the Laboratory of Physiology. Among the many contributions he has made to the field of nutrition research, have been studies of dietary needs and deficiencies.

Hill-Burton Cuts

A cut of slightly more than 50 per cent in federal funds to assist in building hospitals and health centers under the Hill-Burton program has been reflected in appropriations to most states. Delaware, Nevada and Alaska, which in each case had been apportioned the minimum allowance of $200,000 according to the law, received no cut in federal funds.

The reduction in federal funds available for building and construction in the states resulted from the recent federal budget cutback of $75,000,000 for the Hill-Burton program. A total of $150,000,000 had been authorized for the program earlier this year. (For more information on the budget reduction, see "Federal-Legislative" news.)

Heads Blood Donor Drive

Dr. Richard L. Meiling, director of the office of medical services, Department of Defense, has been appointed chairman of the Department of Defense Blood Donor Campaign. As chairman of the campaign, Dr. Meiling will work with the American National Red Cross in directing and coordinating the blood procurement program in the Department of Defense.

Beginning the middle of October, facilities have been available at the Pentagon in Washington, D. C., each Friday to accommodate blood donors.

Health Service Interns

One-year rotating internships under the direction of the Public Health Service will be available in 11 of its marine hospitals beginning on July 1, 1951. Appointments will be made on a competitive basis according to the Uniform Intern Placement Plan.

The internships, of which there will be 122, are open to graduates of approved medical schools. Applicants must qualify for a commission as assistant surgeon in the reserve corps of the Public Health Service and be willing to serve an additional year with the Public Health Service following the year of internship.

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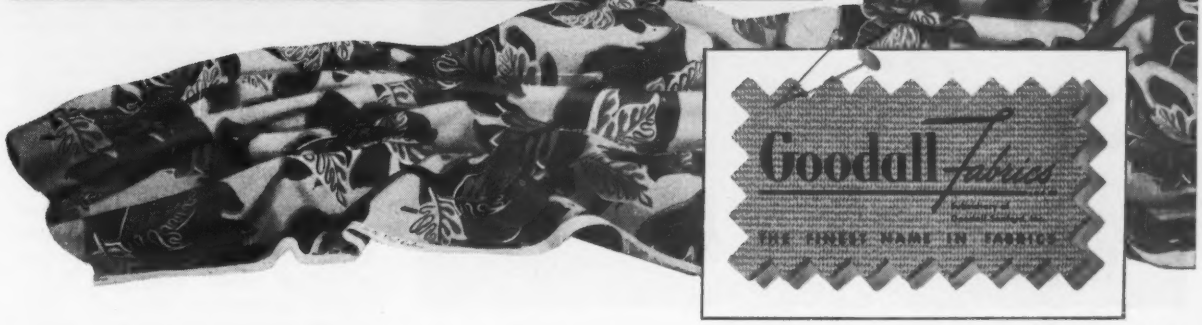

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Chairman of Auxiliaries

Dr. Charles F. Wilinsky, president of the American Hospital Association, has announced the appointment of Mrs. L. L. D. Tuttle, Houston, Texas, as chairman of the Association's Committee on Women's Hospital Auxiliaries. Mrs. Tuttle succeeds Mrs. Amos F. Dixon, Stillwater, N. J., who served as chairman for two years during which time the committee was organized.

As president of her own hospital auxiliary at Methodist Hospital, Houston, Mrs. Tuttle served from 1944-48. One of the major auxiliary accomplishments during this period was the financing of a $10,-500 deep x-ray therapy machine.

In 1948, Mrs. Tuttle was national chairman of the women's section for the annual meeting of the national Board of Methodist Hospitals and Homes, held in Cincinnati. After the 1949 Association convention at which Type V membership was established, Mrs. Tuttle was appointed to the Committee on Women's Hospital Auxiliaries.

An executive committee of 12 appointed persons directs the activities of the auxiliary committee. More than 500 hospital auxiliaries are now holding Type V institutional membership in the Association.

Association of Blood Banks

Mass blood-typing of the civilian population, a proposal that currently is much debated by civil defense planning groups, was not acted upon by the American Association of Blood Banks at its annual meeting in Chicago, October 12-14. Leaders of the association said that action on the question had not been taken by the group and advised that each community should make its own decisions.

Opposition to mass blood-typing has been led by the committee on blood banking of the American Medical Association which believes that it is inadvisable, costly and hazardous. The views of this particular group were expressed in a recent issue of the *Journal of the American Medical Association.*

At the opening session of the three-day meeting, Dr. Thomas H. Seldon, Rochester, Minn., president of the association, told the 500 blood bank representatives that in peace, war, or in event of an atomic attack, no person in this country would die for lack of blood plasma transfusions. Dr. Seldon went on to outline the recent agreement for cooperation between the medical profession and hospitals in supplying blood for all needs.

Dr. Paul I. Hoxworth, Cincinnati, was installed as the new president of the association at the concluding session. The president-elect is J. W. Davenport Jr., New Orleans.

Health Foundation Studies

A resume of the progress made to date by the Health Information Foundation was presented by Adm. William H. P. Blandy, U.S.N., Ret., president, to the first meeting of the foundation's board of directors.

Admiral Blandy reported that the foundation is "making real strides forward in our program and we are now beginning to demonstrate progress in a tangible way."

Two public education projects are now in full operation. Pictorial health messages are being published in more than 1,200 newspapers throughout the country. National leaders in various fields are receiving the foundation's bulletin, "Progress in Health Services."

The final stages have been reached in the foundation's study of the Richmond, Va., multi-phasic clinic project, and plans are being drawn up for the widest possible dissemination of the information from the study.

Admiral Blandy said that preliminary planning is going ahead on the studies of community health facilities and health insurance.

PAST AND present chairmen of the Committee on Women's Hospital Auxiliaries of the American Hospital Association are pictured above. Mrs. Amos F. Dixon, Stillwater, N. J., at left, will be succeeded by Mrs. L. L. D. Tuttle, Houston, Texas, as auxiliary chairman.

Hospital Accountants

A special certificate of appreciation has been given to Indiana University, Bloomington, by the American Association of Hospital Accountants in recognition of the school's services during the past eight years as host to the annual national hospital accounting conference.

The conference, attended by hospital accountants from the entire country, is directed each year by Stanley A. Pressler, professor in the university's school of business.

Ohio Tuberculosis Leaders

Dr. Karl E. Kimber, chief of professional services at the Veterans Administration Hospital, Brecksville, was elected president of the Ohio Tuberculosis Hospital Association at the meeting held in October. He succeeds Dr. William Newcomer, medical director of the

Another hospital-tested product from Simmons *Complete Line

In raised position Vari-Hite Bed places patient at standard bed height for nurse care and treatment. The photograph shows a seven filler Vari-Hite Bed with H-46 saftey sides, which prevent the patient from falling or rolling out of bed. For easy access to the patient, sides drop down and clear the bottom of the mattress simply by releasing spring catch on each side. Bed illustrated, H-880-3 Vari-Hite Bed with H-46 safety sides and L-190 Self-Adjusting spring.

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Here full panel style Vari-Hite Bed is shown lowered to comfortable home height which gives convalescent patients a much greater sense of security. At low height there is no need for a footstool, no need to call the nurse for assistance, less danger of a misstep. Note that H-46 safety sides can be lowered even when the bed is in down position. Spring illustrated is Deckert Multi-position Spring but bed ends can accommodate any of the Simmons posture springs.

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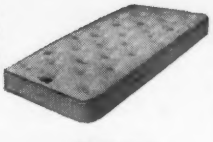
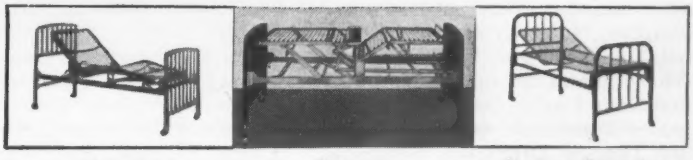


Beautyrest hospital mattresses



Simmons H-800-1-L-190 Self-adjusting Bed

Simmons H-806-L-171 Eye Bed

Simmons flat spring infirmary bed H-600-SCC-H-50

OFFICERS of the Washington State Hospital Association pictured at the annual meeting in Spokane are (seated, at left) president-elect, Chester Finkbeiner, administrator of Central Washington Deaconess Hospital, Wenatchee; immediate past president, Walter A. Heath, director of Tacoma General Hospital, and treasurer, Martin N. Olsen, business manager of Swedish Hospital, Seattle. Standing (at left) are life honorary president, A. L. Howarth, superintendent emeritus and counselor, Central Washington Deaconess Hospital, Wenatchee; president, Horace Turner, administrator of Deaconess Hospital, Spokane; first vice president, Mrs. Cecile T. Spry, administrator of General Hospital of Everett, and the executive secretary, Mrs. Nina Mae Garner, purchasing agent of Tacoma General Hospital.

Mahoning County Tuberculosis Sanatorium, who resigned from the presidency.

Quarterly meetings are held by the association for administrators and business managers of tuberculosis hospitals throughout the state. At the annual meeting in April 1951, to be held in conjunction with the Ohio Hospital Association, a new slate of officers will be elected.

Secretary-treasurer of the association is Dr. James Villani, superintendent of Edwin Shaw Sanatorium, Akron.

Washington State

Washington State Hospital Association held its annual meeting on September 7-8 in Spokane with an attendance of 130. Two roundtable discussions were scheduled on alternatives to federal control of medical and health facilities and on Blue Cross plan activities.

Among other highlights of the state meeting were panel discussions on "internal control of hospital finance" and "patient care." The organization of the Washington State Health Council and proposed legislation were explained by Thomas Drummey, personnel director of Providence Hospital, Seattle.

Officers elected to head the organization, in addition to those pictured on this page, are the second vice president, Mrs. Charlotte Dowler, administrator of Shelton General Hospital, and Sister Reine, administrator of St. Elizabeth Hospital, Yakima. President Horace Turner, administrator of Deaconess Hospital, Spokane, also serves as delegate to the American Hospital Association.

Pharmacists

Officers for 1951-52 have been elected in mail balloting of members of the American Pharmaceutical Association. The newly elected leaders will be installed at the annual convention of the association, to be held in Buffalo, N. Y., the week of August 26, 1951.

Don E. Francke, Ann Arbor, Mich., is president-elect. Other officers who were elected in the mail balloting are: First vice president-elect, Joseph B. Burt, Lincoln, Neb., and second vice president-elect, John A. McCartney, Detroit.

Members-elect of the council, serving a three-year term, are Martin E. Adamo, Boston; Glenn L. Jenkins, Lafayette, Ind., and W. Arthur Purdum, Baltimore.

Henry H. Gregg of Minneapolis is the current president.

Lasker Awards Announced

Recipients of the 1950 Lasker awards have been announced by the Lasker Foundation, and formal presentation of the awards is scheduled for October 31, during the 78th annual meeting of the American Public Health Association, held this year in St. Louis. The awards have been made annually by the Lasker Foundation since 1946 in order to bring to public attention outstanding medical discoveries.

This year's award winners are:

Dr. George Wells Beadle, chairman of the biology division of the California Institute of Technology, for his researches in the field of heredity.

Dr. George Papanicalaou, professor at Cornell University Medical College, for the "wet smear" test he devised to aid in the early detection of cancer.

Dr. Eugene Lindsay Bishop, director of health and safety of the Tennessee Valley Authority, for his outstanding record of 35 years' work in the public health field and his studies of malaria prevention.

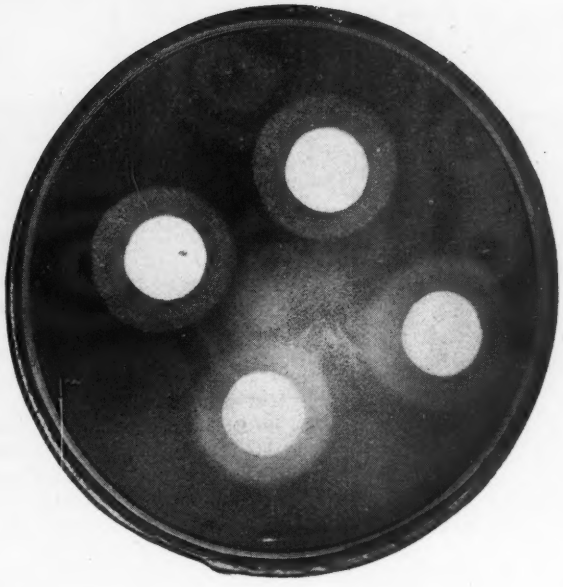
The international health division of the Rockefeller Foundation received the fourth award this year for the work it has done in controlling and eradicating diseases throughout the world. Dr. George K. Strode, director of the division, represented the foundation.

Directs Blood Program

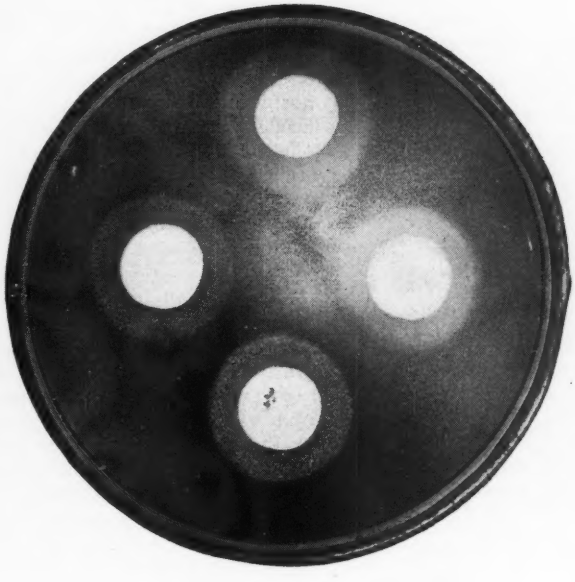
Appointment of Dr. Russell Haden, former director of Cleveland Clinic, as medical director of the American Red Cross national blood program has been announced. According to Dr. Ross T. McIntire, director, Dr. Haden's addition to the Washington headquarters staff on a fulltime basis will give further impetus to a large-scale blood project which already was making encouraging progress. Dr. Haden will work closely with the National Security Resources Board and Department of Defense, both of which have assigned blood-collecting responsibilities to the American Red Cross, and with the American Association of Blood Banks and affiliated hospitals.

National Health Council

Philip E. Nelbach last month became associate director of the National Health Council, a group of 31 national health agencies.



zones of inhibition . . .



By comparison of the zones of complete inhibition of bacterial growth under standard conditions, the superior germicidal properties of Mercresin* Tincture, discovered and developed by Upjohn research workers, can be demonstrated *in vitro*.

Clinically, the marked bacteriostatic, bactericidal and fungicidal properties of Mercresin Tincture have led to its wide use in preparation of operative fields, antisepsis of superficial wounds and infections, irrigation of certain body cavities and deeply infected wounds, and in topical application to mucous membranes.

**Trademark, Reg. U. S. Pat. Off. 'Brand of mercocresols*

Upjohn ***Medicine . . . Produced with care . . . Designed for health***

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Administration Programs Expanding

University programs in hospital administration this year can report significant developments in the training and number of future hospital administrators.

Enrollment figures are at new highs. The University of Pittsburgh and State University of Iowa admitted their first classes in administration this fall. New courses have been added at some schools, and variations have been adopted in field study or residencies to broaden the administration curriculum.

Up 33 per cent: Enrollment this year increased almost 33 per cent over last year, with 213 students registered for fulltime course work. Part-time students are not included in these figures. As in the past, the Naval School of Hospital Administration, Bethesda, Md., directed by Cmdr. M. E. Zimmerman, M.S.C., U.S.N., also is conducting a 10-month training course for 22 members of the Navy Medical Service and Hospital Corps.

Working on their one-year residencies under the direct supervision of administrator-preceptors in selected hospitals are 159 men and women. These people make up the group who will receive graduate degrees in hospital administration in June 1951, although in some cases awarding of the degree is dependent on the presentation of a thesis.

Each year's entering class in hospital administration must be limited in size in order to afford a maximum amount of time for individual work with students. Several schools have increased their classes to admit one or two more this year. Beginning classes at Iowa and Pittsburgh number 10 and 11 students, respectively, and represent the approximate size of class most schools maintain. Dr. Thomas Parran, former surgeon general of the Public Health Service, is director of the graduate school of public health at Pittsburgh, and Gerhard Hartman, Ph.D., superintendent of State University of Iowa Hospitals, is director of the Iowa course.

Organization: In planning the academic and residency program for administration students, course directors have been guided by the semi-annual discussion meetings and criteria of the Association of University Programs in Hospital Administration. Organized in December 1948 with the guidance of the American College of Hospital Administrators, the association now has eight institutional members and two applicants for membership.

INSTITUTES

(For additional information address Association headquarters, 18 E. Division Street, Chicago 10.)

Institute on Hospital Housekeeping—Dec. 4-8; Chicago (Edgewater Beach Hotel).
Institute on Hospital Dietetics—December 4-8; Chicago (Stevens Hotel).
Institute on Medical Record Libraries—Jan. 22-26, 1951; Chicago (Knickerbocker Hotel).
Institute for Nurse Anesthetists—February; Alabama.*
Institute on Housekeeping—spring; Pennsylvania.*
Institute on Dietetics, in conjunction with New England Hospital Assembly—March 29-30; Boston (Statler Hotel).
Institute on Purchasing, in conjunction with Southeastern Hospital Conference—April 2-3; St. Petersburg (Vinoy-Park Hotel).
Institute on Personnel Relations, in conjunction with Midwest Hospital Association—April 9-10; Kansas City, Mo.
Institute on Public Relations, in conjunction with Carolinas-Virginias Hospital Conference—April 24-25; Roanoke, Va. (Roanoke Hotel).
Institute on Personnel Relations, in conjunction with Texas Hospital Association—April 27-28; San Antonio.
Institute on Laundries, in conjunction with Tri-State Hospital Assembly—May 3-4; Chicago (Palmer House).
Institute on Administrative Utilization of Accounting Data, in conjunction with Upper Midwest Hospital Conference—May 14-15; Minneapolis (Nicollet Hotel).
Institute on Credit and Collections, in conjunction with Middle Atlantic Hospital Assembly—May 21-22; Atlantic City.
Institute on Engineering—June 4-8; New York City.
Institute on Personnel Relations—June; California.*
Institute on Dietetics—June; California.*
Institute on Public Relations—June 18-20; Princeton, N. J.
Institute on Purchasing—Oct. 22-26, 1951; Highland Park, Ill.
Institute on Establishment—Nov. 5-9, 1951; Washington, D. C.
Institute on Personnel Relations—November; Virginia.*
Institute on Laundries—November; New England states.*
Institute on Dietetics—December.*

*The exact date and location of the institute will be announced later.

Charter members were the programs at Chicago, headed by Dr. Arthur C. Bachmeyer; Northwestern, with Dr. Malcolm T. MacEachern as director; Columbia, directed by Dr. John E. Gorrell; Minnesota, headed by James A. Hamilton; Toronto, under the direction of Dr. Harvey Agnew; Washington University of St. Louis, under Dr. Frank R. Bradley, and Yale, where George S. Buis directs the program.

In December 1949 the program at St. Louis University, under the direction of Rev. John J. Flanagan, was admitted to full membership. Applying for membership this year are California and Johns Hopkins where R. J. Stull and Dr. Edwin L. Crosby, respectively, direct the programs.

Membership requirements: In order to be eligible for membership, the administrative program must be affiliated with a recognized institution of higher learning and grant, to students completing all required work, a master's degree or its equivalent from the university. Under the tutelage of at least two professors who are competent hospital administrators with full academic status, students must be offered a program primarily designed to train them for hospital administration. A year of residency following the academic year is required.

The association of university programs spells out general standards and conditions for conducting advanced training in hospital administration. Each program, however, may introduce new courses and experiment with field work or the residency in order to give wider experience to the students.

What they offer: At Northwestern this year new courses in hospital equipment and hospital planning and construction are being taught. Washington University is offering for the first time "Hospital Fund Accounting," a special program in financial transactions of hospitals. Group dynamics, an advanced course in handling groups of people by the spoken word, is being developed experimentally at Washington University.

Joint seminars were introduced this fall at Columbia University for administration students and

The statement below* on Contour Sheets was submitted to a group of hospital users picked at random from our files. We told them frankly we wanted to use it in advertising, asked them to read it carefully and return it with their comments. They not only agreed with it, they told us we were too conservative. We were amazed at their enthusiasm. You'll be amazed at Contour Sheets.

Pacific CONTOUR SHEETS

- **Simplify Patient Care**
- **Save Nurses' Time**
- **Reduce Laundry and Replacement Costs**

***"PACIFIC Contour Sheets are easy to put on . . . wrinkle free and wrinkle proof . . . stay tight and smooth . . . can't pull out . . . no mussing or bunching, no matter how often back rest and knee rest are raised and lowered . . . greater comfort for patients . . . less irritation, less danger of bed sores . . . save bed making time and effort . . . no need for frequent straightening of bottom sheet . . . fewer sheet changes . . . less washing . . . less wear . . . actually cut both laundry and replacements costs."**

Read the above statement over again, one clause at a time—*"wrinkle free"—"stay smooth"—"save time"—"cut costs."* Strong statements! Yet each individual clause, based on fact and experience, has not only been corroborated but corroborated *enthusiastically* by hospital personnel — superintendents, purchasing agents, supervisors, housekeepers, nurses, laundry managers. Under the circumstances, don't you think you should try Contour Sheets in your hospital?

Contour Sheets for Hospital Mattresses, made by Pacific Mills, are nationally distributed by

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Manufacturers and Distributors of Hospital and Sanatorium Equipment and Supplies

Milwaukee 12, Wisconsin

the nursing service administration class at Teachers College. With the cooperation of other university departments, stronger offerings in personnel administration are being planned at Yale.

Iowa's new program of hospital administration includes the first specialized course in clinic management to be offered by any of the university programs. Four students are enrolled in clinic management at the university and will do their residencies in clinics.

Field work, an important part of the academic year, gives students brief periods of on-the-job training in neighboring hospitals. At St. Louis University a new angle in field work experience will be offered by sending teams of three students to one of five hospitals in the area where they will be assigned project studies by the hospital administrators. This is a first-semester project, to be followed by a hospital survey during the second semester.

Yale University requires an administrative case study of hospitals in the area prepared by teams of two students and presented to the faculty, class and administrators of hospitals concerned as a formal paper.

Working knowledge: During the residency, administration students under the close supervision of the preceptor are expected to gain a working knowledge of all hospital departments. In most cases the year is spent at a single hospital. Johns Hopkins, however, is experimenting with split residencies, giving students six months' experience in each of two hospitals.

The new program at Iowa also presents an innovation in that the residency is two years in length.

Duke Hospital's administrative program, directed by Superintendent F. Ross Porter, is unlike the other 12 which offer advanced training. It consists of two years' on-the-job training in the various hospital departments. Seminars and extended field trips supplement training. The eight students who complete the course each year receive certificates from the hospital and may, with additional course work at Duke University, receive a master's degree.

Although a detailed report is not available on the training and background of students entering in this year's administration classes, a few general facts are known. Admission requirements in all 13 courses call for a bachelor's degree and a satisfactory academic record. Course requirements very frequently specify undergraduate work in statistics or accounting and a general knowledge of the social sciences.

At Pittsburgh, Toronto, Columbia and California, with a combined total enrollment of 65, there are 11 physicians beginning administration studies. One of the conclusions reached at the joint meeting of the Kellogg Foundation and the Association of University Programs in Hospital Administration last May was that more medically trained men and women should be interested in administering hospitals.

Variety of backgrounds: In addition to seven physicians enrolled in this year's class at Columbia University, the student body includes seven nurses, two assistant hospital administrators, and one representative each of the following: Hospital administrator, accountant, attorney, business manager, pharmacist, personnel director, venereal disease control officer, hotel manager, high school teacher and social service worker. Five students have entered directly from other academic work.

Although not training students for administrative positions of great responsibility, many universities offer pre-administrative courses for undergraduates. Several of these programs are similar to that at California where students receive pre-administrative training, complete a one-year internship, and then enter graduate school for the two-year program.

In addition to their fulltime graduate students, most administration programs attract as part-time students professional workers in the field who are interested in taking one or two courses in the core curriculum. The opportunities for advanced training which are now offered by the 13 programs in hospital administration insure an increasing number of professionally equipped administrators.

1950 ENROLLMENT

New enrollment figures for each of the courses in hospital administration are listed below. Students who began their academic work this fall normally will graduate in June 1952. Listed also are the number of residents each university program in hospital administration expects to graduate with advanced degrees in 1951.

School	1950 enrollment	1951 graduates
Columbia University	32	20
Duke Hospital	7	8
Johns Hopkins University	5[1]	4
Northwestern University	45[2]	48
St. Louis University	14	6
State University of Iowa	10	....
University of California	9	3
University of Chicago	12	12
University of Minnesota	30	22
University of Pittsburgh	11	....
University of Toronto	13	12
Washington University	17	17
Yale University	8	7

1. Twenty-two students are enrolled in the program, taking part or fulltime work. Approximately five students in the class will complete the requirements for a master's degree.

2. In addition there are 33 students enrolled on a part-time basis. Students in the pre-administration course are included in these figures.

Laundry Management

Pacific Mills is again offering 10 scholarships to employees of Association institutional members to cover the cost of a university sponsored short course. Earlier this year 10 students were awarded scholarships to attend the Michigan State College short course in hospital housekeeping.

The newly announced scholarships will enable employees in the laundry departments of Association hospitals to attend the hospital laundry management course, offered by the University of Iowa, Iowa City, from February 12 to March 30. Full information about the course and scholarships is being mailed to all institutional members of the Association. Details of the course are included in "Laundry Management Comment," page 95 of this issue of HOSPITALS.

Dr. MacEachern Honored

McGill University, Montreal, has awarded an honorary doctor of laws degree to Dr. Malcolm T. MacEachern, director emeritus of the American College of Surgeons and director of the Northwestern University course in hospital administration. The ceremony took place at the founders' day convocation of the university, October 6.

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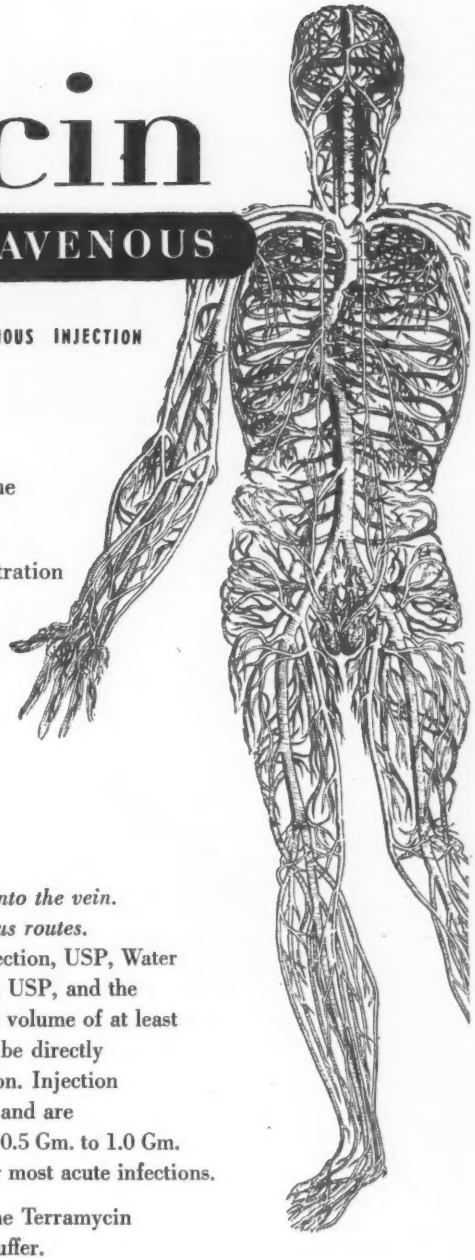
for hospital use only INTRAVENOUS

CRYSTALLINE TERRAMYCIN HYDROCHLORIDE FOR INTRAVENOUS INJECTION



Affords the advantages of intravenous therapy with the newest of the broad-spectrum antibiotics in:

... those conditions and cases in which oral administration is not feasible;

... severe, fulminating or necrotizing infections (by rapidly producing high serum concentrations);

... pre- and post-operative prophylaxis;

... peritonitis.

Dosage and Administration:

Terramycin Intravenous should be injected directly into the vein. It is never given by the intramuscular or subcutaneous routes. Each vial is dissolved in sterile 5% Dextrose for Injection, USP, Water for Injection, USP, or Physiological Saline Solution, USP, and the resultant clear solution further diluted to give a final volume of at least 100 cc. When desired, Terramycin Intravenous may be directly introduced into solutions for continuous drip infusion. Injection solutions should not contain more than 5 mg. per cc. and are injected slowly, not exceeding 100 cc. in five minutes. 0.5 Gm. to 1.0 Gm. in divided doses q. 12 h. has been found adequate for most acute infections.

Supplied: 10 cc. vials containing 250 mg. of Crystalline Terramycin Hydrochloride with sodium glycinate as a buffer.
20 cc. vials containing 500 mg. of Crystalline Terramycin Hydrochloride with sodium glycinate as a buffer.

Antibiotic Division Pfizer CHAS. PFIZER & CO., INC., *Brooklyn 6, N.Y.*

Isotope Center for State

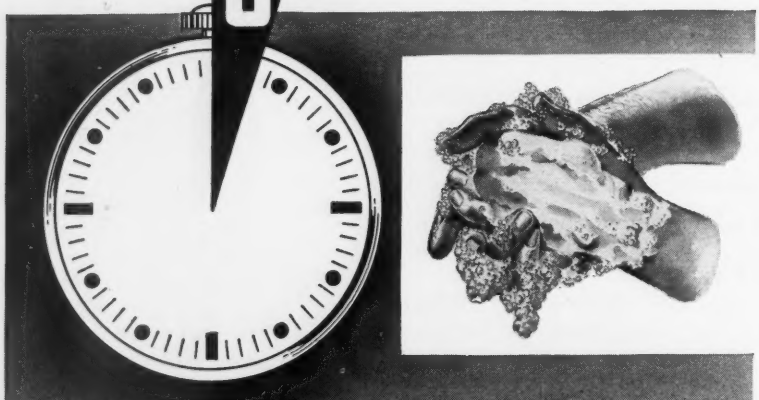
A cooperative state-wide plan to provide radioactive isotopes for the diagnosis and treatment of cancer patients is now being established at Newark (N. J.) Beth Israel Hospital. The first attempt to make such facilities available to all the people of a state, the plan may be extended later with the creation of sub-centers in other parts of the state.

Housing and central headquarters of the isotope system will be at Beth Israel Hospital where a new $12,000 laboratory is under construction. The New Jersey division of the American Cancer Society made a grant of $2,500 to the hospital toward the cost, and the U. S. Atomic Energy Commission has approved the project.

The laboratory will be directed by Dr. Louis J. Levinson and Dr. Lester M. Goldman of the Beth Israel staff.

Surgically Clean Hands

In Only 3 MINUTES



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Antiseptic Liquid Soap

Containing HEXACHLOROPHENE

SEPTISOL enables the surgeon to secure bacteriologically cleaner hands in less than ⅓ the time required by conventional scrubbing methods. He, and members of the operating team, can eliminate irritating brush-scrubbing and antiseptic after-rinses from their scrub routine because such procedures are not necessary with SEPTISOL.

The elimination of brushes and rinses saves the hands from needless abuse. In addition, SEPTISOL contains a vegetable emollient that leaves the hands soft and clean. This emollient and the low pH of SEPTISOL prevents keratolytic action and "soap irritation".

Over 10 million scrubs in hundreds of hospitals have proven SEPTISOL non-irritating to the normal skin.

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Proposed Expansion at Iowa

Construction of a new five-story wing and revamping of parts of the present building have been suggested in a $3,000,000 improvement program at the University of Iowa medical center in Iowa City.

If the proposed plan is undertaken, three new functions would be added to the hospital's services. A psychiatric patient care unit with a complement of 30 beds would work closely with the state mental institutions as a screening center and provide facilities for the care of acutely physically ill patients who demonstrate severe psychiatric problems as well.

A suggested premature infant center to care for 25 infants would serve the entire eastern one-third of the state.

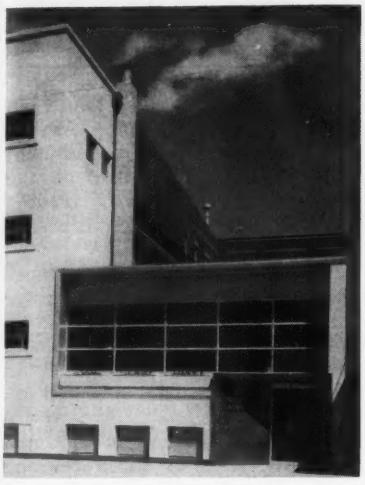
An experimental geriatrics and chronic disease unit would provide bed-care for 50 patients and outpatient services as well. In addition to providing hospital and medical care to the elderly, the suggested geriatrics unit would conduct pilot surveys throughout the state.

New Addition to Clinic

First opened in 1929 with a complement of 10 beds, the Brewster Hospital and Clinic, Holdrege, Neb., now has 60 hospital beds, a staff of six doctors in the clinic and an area of service extending throughout southwest Nebraska and northeast Kansas.

The most recent remodeling and expansion, completed early this fall, added new rooms, a lobby and reception room, offices and two more operating suites. Air conditioning throughout and a sprinkler system were installed.

Founder of the hospital, Dr. Frank A. Brewster, received much publicity several years ago as the "flying doctor" who piloted his own plane to reach patients.



REMODELING at the Brewster Hospital and Clinic, Holdrege, Neb., added a modernistic entrance and large lobby to the building.

Harold J. Hamilton is administrator and business manager of the Brewster Hospital.

Hospital Dedication

A new 56-bed hospital in Carthage, Ill., was dedicated recently with formalities attended by more than 3,000 residents of the community. Principal speaker in the Memorial Hospital dedication program was Dr. Malcolm T. MacEachern, director of the Northwestern University course in hospital administration.

In commending the community spirit that brought about the hospital, Dr. MacEachern said, "I would rather have a hospital with an endowment of community spirit than dollars."

John James is administrator.

Plan for 1,594 Patients

New York City's big new Tuberculosis and Chronic Disease Hospital is now in the final stages of planning and should be in construction a year from now. With 1,594 beds, the 11-story building will be on Welfare Island, between the Metropolitan Hospital and city homes.

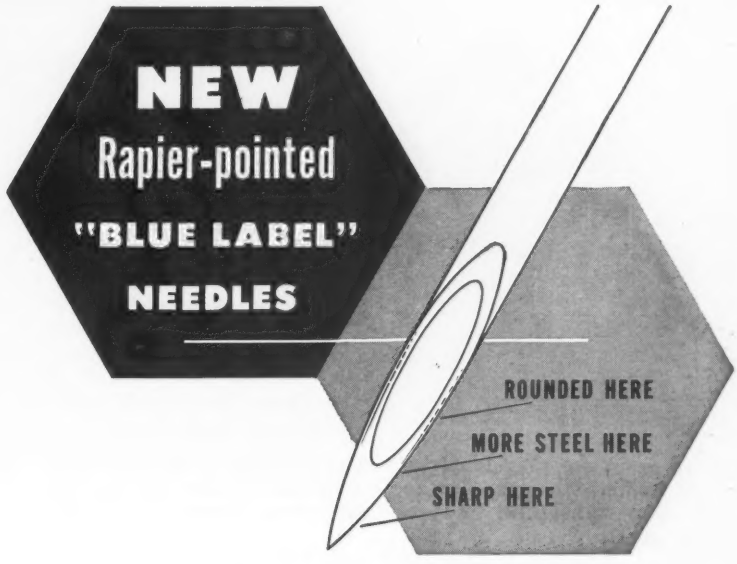
Originally proposed as two separate buildings housing tuberculosis and chronic disease patients, the hospital plans were revised for reasons of economy to a one-structure building. Total costs will be about $21,300,000.

A staff of 2,500 employees will be necessary to care for the 500 tubercular and 1,000 chronic disease patients. Two medical superintendents and two deputy superintendents will direct hospital services, and a staff of 78 resident physicians is anticipated.

Expansion Program

A remodeling and expansion program at St. Francis Hospital, Marceline, Mo., will add 14 beds to the present capacity of 16 beds, according to Sister M. Reinholda, O.S.F., superintendent of the hospital. The new addition, on which work will begin late this summer, is estimated to cost $200,000.

St. Francis Hospital has been owned and operated since 1946 by the School Sisters of St. Francis whose motherhouse is in Chillicothe, Mo. The hospital formerly was the B. B. Putman Memorial Hospital, but was closed following the serious injury of Dr. Putman in an automobile accident in 1942.



Minimize Trauma, Pain and Leakage

Conventional hypodermic needles are like miniature biopsy needles—they cut out tiny cylinders of tissue removing nerve elements. In tissue so traumatized, pain lingers and the medication may leak out along the path of the needle.

The rapier-points and rounded edges of "Blue Label" Needles are designed to penetrate by parting rather than by painfully slicing tissue fibers. Rapier-points are stronger—stay sharp longer because they contain more metal than conventional needles. These hand-honed needles are subjected to painstaking control and inspection at every stage of manufacture to insure freedom from chips, burrs and abrasives. Thus, "Blue Label" Needles offer hospitals definite savings in time and money. Why not order a supply today from your nearest surgical supply dealer? J. Bishop & Co. Platinum Works, Medical Products Division, Malvern, Pa. In Canada: Johnson Matthey & Mallory Co., Ltd., 110 Industry Street, Mt. Dennis, Toronto 16.

BISHOP "BLUE LABEL" NEEDLES

Made of 18-8, the safe stainless steel

SERVICE TO SCIENCE AND INDUSTRY SINCE 1842

Approval Program Revised

A concise restatement of the responsibility of hospitals and Blue Cross plans to Blue Cross subscribers and the conditions for approval of plans has been worked out jointly by the American Hospital Association and the Blue Cross Commission. At the House of Delegates meeting in Atlantic City, during the Association convention, the new approval standards, titled "General Principles and Standards for Approval of Blue Cross Plans," were adopted.

The revised statement spells out in greater detail the relationship between hospitals and plans than did the former statement. Among the provisions is the requirement that "at least one-third of the members of a plan's governing board shall be representatives of the contracting hospitals."

Blue Cross plan certificates specifically must cover "an average of not less than 75 per cent of the total amount billed for usual and customary hospital services" in the accommodations specified on the certificate.

Plan participation in national programs, such as those relating to the transfer of members and the Inter-Plan Service Bank, has been regulated. The new standards specify that plans "shall participate in all national programs in which at least three-fourths of all plans representing also at least three-fourths of the weighted vote of all plans are participating."

A special committee was appointed by the Blue Cross Commission in April 1949 to review the approval program. Chairman of the committee was Dr. Basil C. MacLean, director of Strong Memorial Hospital, Rochester, N.Y., and a member of the Blue Cross Commission. Working with him were James E. Stuart, executive vice-president, Hospital Care Corporation, Cincinnati, and Harold V. Maybee, managing director, Group Hospital Service, Inc., Wilmington, Del.

Higher Blue Cross Assets

Admitted assets of the 89 Blue Cross plans had increased 24.63 per cent on June 30, 1950, as compared with the assets reported on the same date in 1949. The financial experience of Blue Cross plans during the first six months of 1950 has been summarized in a special study released by the Blue Cross Commission.

An increase in assets of 11.51 per cent since December 31, 1949, was also reported. Latest figures known on Blue Cross plan assets put them at $210,767,416.

In an analysis of other financial data gathered at the end of the six-month period, the commission reported that total reserves represented $2.68 per participant as compared to $2.36 per participant one year ago, an increase of 13.56 per cent.

Busy Industrialists Stop—Think—Give To Hospital Drive

LAWSON ASSOCIATES know that in a hospital fund raising campaign the top executive of an industrial plant is more than a man who sits in a solitary office and thinks only of production problems.

Take the industrialists in Lancaster, Pa. They got behind the campaign for a new and modernized St. Joseph's hospital because they were convinced of the need.

The money Lancaster industries gave totaled $292,048—a figure that was nearly one third of the $963,530 subscribed in the drive. In short, 106 industries, large and small, gave an average of $2755.

Lancaster industries are like industries throughout the United States. They have community spirit. But many times, like other members of the community, they have to be convinced that a hospital project not only helps the community but aids them as well.

They have to be shown, through an intensive public relations program, that their plants are kept operating more efficiently because a modern hospital guards the health of their workers and their families.

They have to be shown that such a hospital further pays dividends by providing emergency treatment and hospitalization for employes who are injured on their jobs.

Let the successful fund raising methods of LAWSON ASSOCIATES sell the need for your projected new or enlarged hospital if you are considering an appeal to the public.

Remember that preliminary consultations and surveys are made without obligation to you. For more information about our fund raising methods write today to Department A-11 for the illustrated brochure "Fund Raising."

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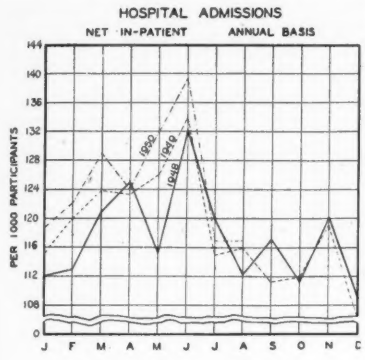
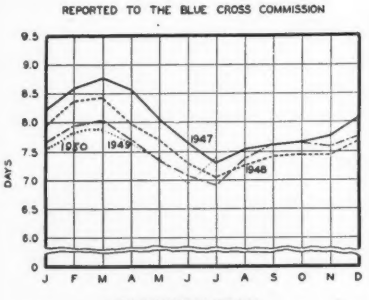
Hospitalized Blue Cross members took 89.61 per cent of the total earned subscription income, which during the first six months of the year amounted to more than $222,380,000.

Other Semi-annual Data

Admission rates per thousand participants for the first six months of 1950 averaged 128 for all plans, as compared to 124 for the same period last year. Fewest admissions were reported for January, and June had the largest number, but each month's rate was higher than that of the corresponding month last year.

Inpatient admissions for the first

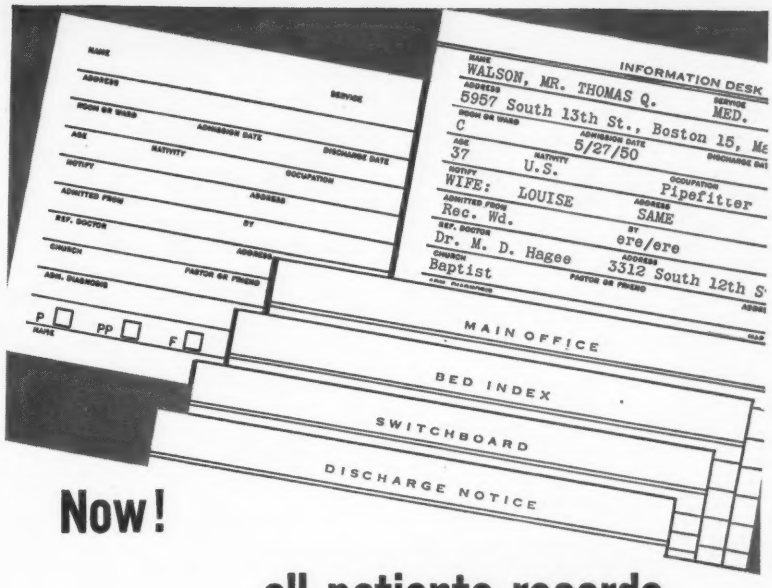




ADMISSION-STAY

The net inpatient admission rate decreased in July to 117 per 1,000 Blue Cross members and remained stationary at that figure through August. This is an average decrease of 22 per 1,000 members from the very high admission rate for June, 139 per 1,000 members. During both July and August 1949, the admission rates were slightly lower than for this year. In July 1949, there was a rate of 115 per 1,000 members and in August 1949 a rate of 116 per 1,000 Blue Cross members entered hospitals.

The average length of stay for hospitalized Blue Cross members decreased from 7.39 days during May to 6.96 days in June, and then increased during July to 7.04 days. For the past three years the lowest monthly average rate of stay has been during July. This year, however, the June figure of 6.96 is the lowest to date. It is higher than the length of stay for July 1949 which was 6.93 and was the lowest for that year. The average length of stay for June 1949 was 7.09.



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half of this year were almost 283,000 more than the figure for last year during the same period. Admissions reported by the 90 plans totalled 2,340,330.

In addition to providing bed care, the 79 plans which reported outpatient service had a total of 295,444 such admissions. This was 18 per thousand members, an increase of two over 1949, when 71 plans had a rate of 16 for the first six months.

Blue Shield for Maryland

Enrollment of members began early this fall for a new Blue Shield plan, the Maryland Medical Service. More than 1,300 physicians throughout the state are participating in the program which is under the medical direction of Dr. Richard F. Kieffer.

Administration of the Maryland Blue Shield plan is by Maryland Hospital Service, the Blue Cross plan, and a combined membership was offered first to members of Blue Cross.

Provisions of the new plan call for complete payment of a participating doctor's bill if the subscriber is single with an income of $3,000 or less, or if he is married and has a total family income of not more than $3,600. Subscription charges are $.70 for an individual, $1.70 for husband and wife, and $3.60 for family coverage, including benefits for maternity cases.

Six New Plans in Bank

The Inter-Plan Service Benefit Bank of the Blue Cross Commission announced that six more plans are participating in it since the beginning of October, and one has withdrawn, making a total of 69 plans which are now members of the bank.

New participating plans are those with headquarters in Wilmington, Del.; Jamestown, N. Y.; Rochester, N. Y.; Syracuse, N. Y.; Watertown, N. Y., and Bluefield, W. Va.

The Alton, Ill., plan which merged earlier this year with the St. Louis plan, is no longer participating in the Inter-Plan Service Benefit Bank although its subscribers receive the benefits through the St. Louis Blue Cross organization.

A temporary withdrawal from participation went into effect on October 1, for the Rockford, Ill., plan.

Quarterly Bank Report

A net gain of close to $16,000 was reported by the Inter-Plan Service Benefit Bank for the third quarter of the year during which host plans were paid $2,425,818 for services to their subscribers. The Blue Cross Commission announced also that the third quarter was the largest in volume of cases processed since the start of the bank.

The bank cleared a total of 27,685 cases during the summer months. To date the bank has processed 74,552 cases during the year, representing 553,464.7 days of hospital care.

A slightly longer than average length of stay continues to characterize bank cases. The average length of stay for all Blue Cross inpatient admissions in July was 7.04 days; for bank cases the average length of stay, also in July, was 7.20.

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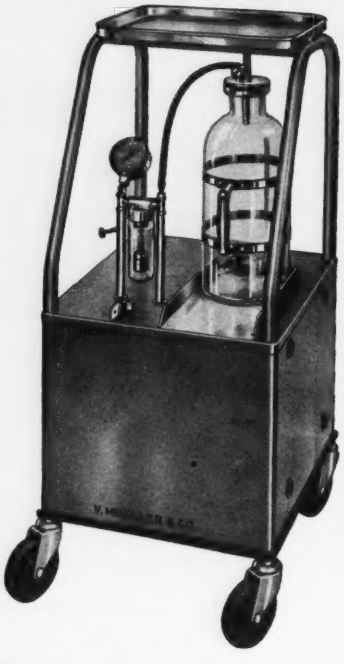

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Outstanding!
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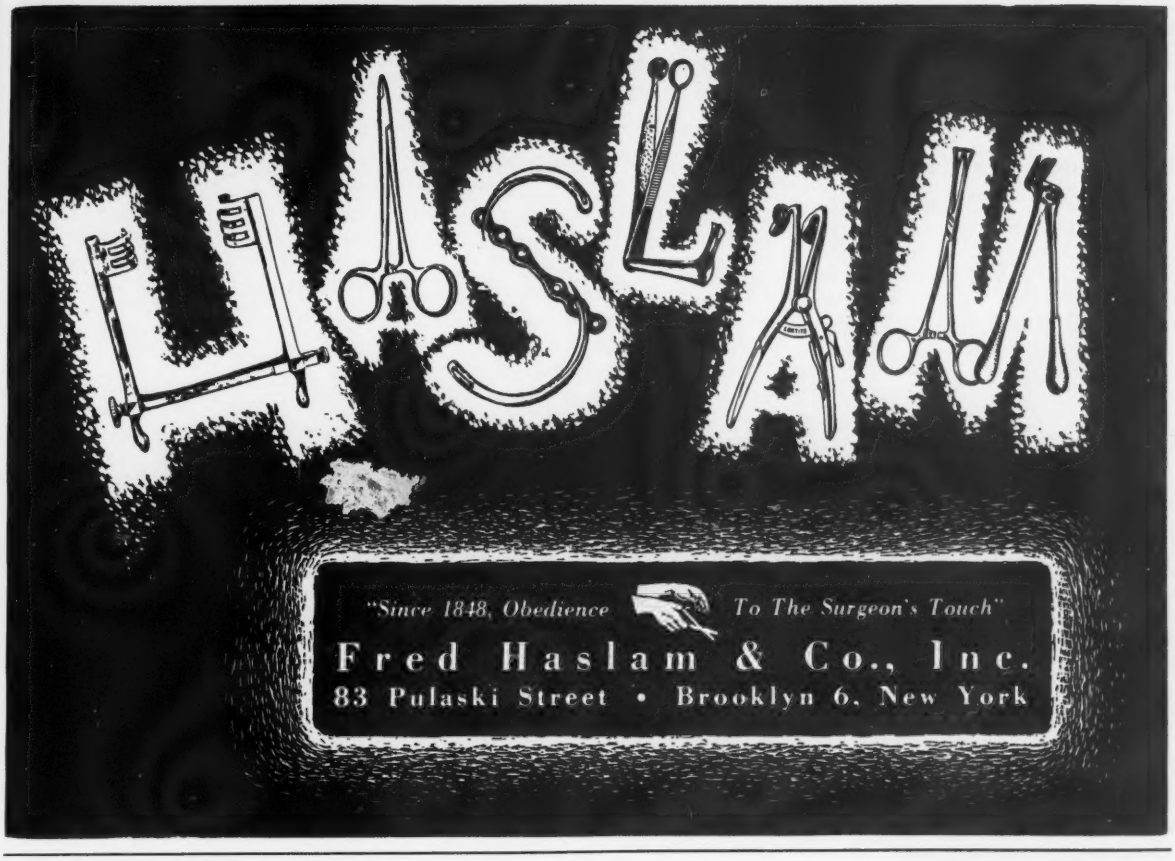

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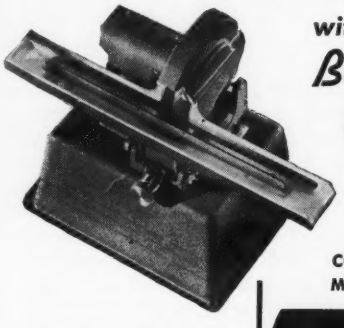

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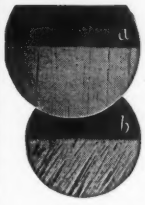

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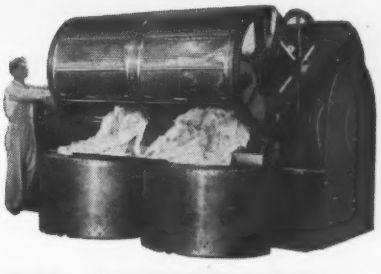

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Emergency Training Urged

Immediate training of volunteer nurses aides for service in emergency situations was urged by Dr. Marcus D. Kogel, commissioner of hospitals in New York City, at an October meeting of the Greater New York Hospital Association.

As director of the medical emergency division of civil defense for New York City, Dr. Kogel suggested that hospitals take the initiative in recruiting and training volunteers for work during a possible atomic attack. Retired nurses, he said, were an excellent source of volunteers.

Training programs for volunteer nurses aides should stress "ordinary first aid, not professional first aid," for shock, burns and injuries, Dr. Kogel said, and added that recruitment should be started immediately, preferably in the community surrounding the hospital so that transportation would be cut to a minimum.

Among other suggestions Dr. Kogel made for the preparation of hospitals to meet emergency situations was to maintain a full stock of certain supplies. Whole blood, plasma, saline solutions, dressings and various drugs would be needed in quantity during a mass emergency period.

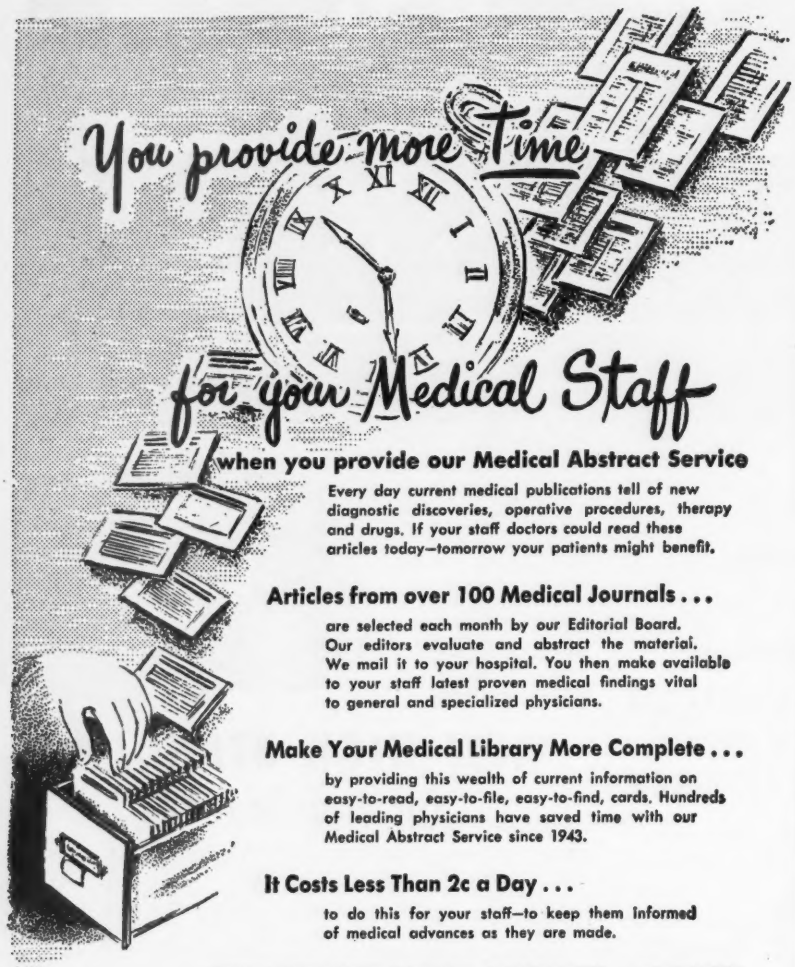
Visit of Swedish Nurse

Surgeon General Leonard A. Scheele and Lucile Petry, assistant surgeon general and chief nurse officer of the Public Health Service, conferred with Gerda Hojer, president of the International Council of Nurses, upon her arrival in Washington from Sweden in mid-October. Later in the month Miss Hojer, who is a member of the Swedish parliament, was scheduled to address the California State Nurses' Association at its annual meeting in Los Angeles. During her United States visit, she will confer with officials of hospitals and other institutions in various parts of the country. Miss Hojer's objectives are improvement of nursing services and education on a global basis and the development of an international exchange of information on nursing affairs. Before leaving Washington, she addressed the annual banquet of the Graduate Nurses' Association of the District of Columbia.

Fall Admissions

Mid-August figures on enrollment of first-year nursing students indicated that 84 per cent of the goal for the fall class had been achieved at that time in the 1950 nurse recruitment campaign. The National League of Nursing Education released the August admission figures, following a postcard survey of every state approved school of nursing which resulted in replies from 1,097 schools.

Applications accepted for the fall class numbered 36,461 on August 15.



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State-wide Blood Banking

A blood banking agreement effective throughout the state of California for civilian blood donors was announced the end of September by the California Medical Association and the American Red Cross.

It is the first state-wide program to be established under the terms of the so-called Boston Agreement, worked out at a conference this summer of the four national organizations participating in the Committee on Blood Banking. Represented in the committee are the American Hospital Association, American National Red Cross, American Association of Blood Banks and American Medical Association, together with the National Security Resources Board.

California's new blood banking program allows donors to make replacements of blood any place in the state, regardless of where the transfusion was given.

Free exchange: The national blood banking program adopted by the Committee on Blood Banking at the Boston conference in July was an agreement by the four groups that in time of peace there should be a free exchange of blood between the variously operated blood banks and blood centers in order to best serve the community. The four groups also favored, "as a principle," making surplus blood available to the Red Cross or other agencies processing blood for the purpose of converting it into derivatives for the benefit of the people.

During a national emergency, the agreement stated that Red Cross blood donor centers should be established to procure blood in communities not previously served by the Red Cross blood program.

New York Hospital Board

At the first meeting of the board of hospitals, policy-making body of the New York City Department of Hospitals, the establishment of major committees to carry on the board's functions was considered. Activities of this board will be directed toward developing and maintaining long-range programs for the care of the sick, injured,

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aged and infirm persons who are the responsibility of the department.

Committees are being created on the special subjects of hospital construction and planning, creation of a hospital code and proprietary hospital licensure.

Miners Revise Benefits

New revisions to the hospital and disability benefit program financed by the United Mine Workers Welfare and Retirement Fund were announced during October and supplement those reported in HOSPITALS for August, page 117.

Under the benefit schedule in operation during 1949, the fund ended up with a deficit, and the entire program had to be discontinued. A new benefit program, considerably limited in comparison with the old, went into effect in July.

As it now stands, benefits will cost about $2,000,000 a month. The entire program is financed by industry payments of 30 cents for each ton of coal mined under United Mine Workers contracts with operators, representing an annual income for the fund of $150,000,000.

The most recent announcement of revised benefits spelled out conditions and amounts of pensions to disabled miners and to widows of miners. All widows and dependent children will receive the same hospital and medical care which is provided for the mine workers. Adult dependents of living miners will be limited to 60 days of hospital services each year.

Rheumatic Fever Research

A new $10,000 grant from the Association for the Aid of Crippled Children will enable the department of preventive medicine of New York University College of Medicine to continue research on its rheumatic fever and heart disease program.

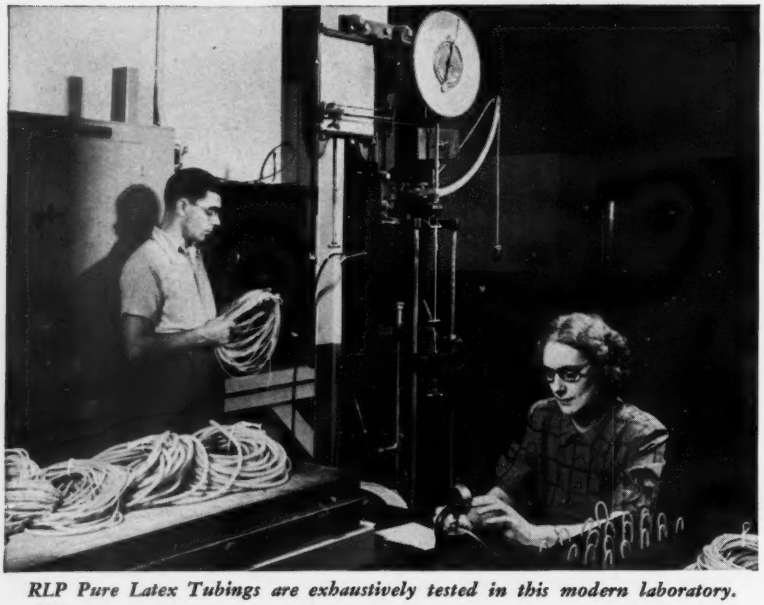
The project currently is studying administrative practices for case finding and follow-up of children with these conditions. Eventually it hopes to develop in one health center district a rheumatic fever and heart disease program which can be adopted by the New York City health department and extended to a city-wide program.

Additional financial support has been promised by the New York Heart Association which has made grants during the three and a half years of the project.

Patients' Complaints

Thirty-four state medical associations now have established procedures for hearing complaints of patients against the services or charges of their physicians. A review of this rapidly expanding activity undertaken in the interest of better patient-physician relationships was in a recent issue of the *Journal of the American Medical Association.*

Patients who take complaints of any sort to the committees on professional conduct, as the state groups frequently are named, may expect a thorough hearing from the group and recommendations for solution of the problem. Discipline will be exercised by the committee and state medical associations where such is necessary, and in extreme cases the society may ask for revocation of the physician's license.



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Public grievances are handled by the governing council of the state medical association in Georgia, Kansas, Louisiana, Minnesota and Nevada. Local committees have been set up in some communities to supplement the work of state committees.

New Retirement Program

St. Mary's Hospital, Evansville, Ind., has instituted a new retirement program which appears to have the hearty support of hospital employees. Ninety-five per cent of workers eligible to enroll in the program have signed up. There are about 250 employees, all of whom are potentially eligible with the exception of physicians.

Originally tested for four years in Texas hospitals operated by the religious order of Daughters of Charity, the retirement program may be extended to all the 53 Daughters of Charity hospitals.

Under the system the employee contributes three per cent of his monthly salary to the retirement fund, and the Daughters of Charity puts up five per cent. When retirement comes at the age of 65, the employee will have his choice of taking a lump sum, which will amount to around $17,000 for a nurse who has spent most of her working time at St. Mary's, or of receiving a lifetime pension.

Membership in the program is open to all employees after two years work at the hospital. Persons leaving the hospital's employment after five years tenure there will be refunded the amount they contributed, plus two per cent interest and a part of the money paid into the fund by the hospital. A worker who leaves with two to five years working time will receive only his payments to the fund and interest.

Although no provision is made in the program for retroactive coverage, it does offer partial compensation to old employees for their services before the plan was adopted. The hospital computes the number of years during which the

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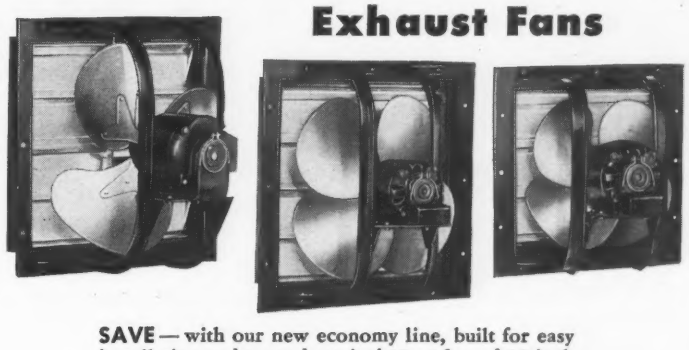

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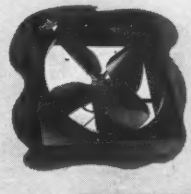

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employee would have been eligible had the retirement program been in effect and adds three-fourths per cent for each year to the amount it contributes monthly to the fund.

Sister Justina is administrator of St. Mary's Hospital, and Sam Virts is personnel manager.

"Careers for Men"

One of two new pamphlets issued by the Committee on Careers in Nursing is titled "Careers for Men in Nursing" and was written in response to the large number of inquiries received from men about career opportunities in nursing. Publication of this and the other new folder produced by the committee, "Nursing and College," was financed by a grant from the National Foundation for Infantile Paralysis.

"Nursing is a 'natural' for many men," reads the folder, "because it offers a variety of outlets for personal interests and abilities." Sports enthusiasts, those with mechanical or scientific aptitudes may find in nursing many opportunities for exercising their abilities.

There are 183 schools of nursing which accept men students, a gain of 60 during the past year.

Alton for example: Out of 37 freshman students at St. Joseph's Hospital school of nursing, Alton, Ill., six are men, according to Sister Angela, director of nursing at St. Joseph's. Sister Helen is administrator of the hospital.

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Tucson—Barfield Convalescent Hospital

CALIFORNIA
Banning—San Gorgonio Memorial Hospital
Dinuba—Alta Local Hospital
San Andreas—Mark Twain Hospital
San Diego—Quintard Hospital Corporation
Stanford—Stanford Convalescent Home
South Pasadena—Braewood Hospital

COLORADO
Akron—Washington County Public Hospital
Aspen—Pitkin County Public Hospital
Craig—The Memorial Hospital
Florence—St. Joseph Hospital
Pueblo—Colorado State Hospital
Yuma—Yuma Community Hospital

ILLINOIS
Chicago—Catherine Booth Hospital and Clinics
Paxton—Paxton Community Hospital
Robinson—The Schmidt Hospital

INDIANA
Columbia City—Memorial Hospital
Columbia City—Whitley County Memorial Hospital
South Bend—Northern Indiana Children's Hospital

IOWA
Woodward—Woodward State Hospital and School

KANSAS
Eureka—Basham Hospital
Kinsley—Edwards County Hospital

MAINE
Augusta—Department of Health and Welfare

MICHIGAN
Detroit—Lakeside General Hospital

MINNESOTA
Duluth—The Birches Sanitarium, Inc.
Marshall—Louis Weiner Memorial Hospital
Zumbrota—Zumbrota Community Hospital

MISSISSIPPI
Biloxi—New Biloxi Hospital, Inc.

MISSOURI
Kansas City—The Major Clinic and Hospital

NEW YORK
Ithaca—Hermann M. Biggs Memorial Hospital
Jamaica—Mary Immaculate Hospital
Liberty—Maimonides Lodge Hospital Association
Mount Morris—Mount Morris Tuberculosis Hospital
Newburgh—Estelle and Walter C. Odell Memorial Sanitarium
New York—Mount Morris Park Hospital
Oneonta—Homer Folks Tuberculosis Hospital
Perrysburg—J. N. Adams Memorial Hospital

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Too Many Small Hospitals?

(Continued from page 44)

Recently, however, we have been given a good demonstration of how doctors can be attracted to practice in a rural state.

Under the leadership of Dr. Franklin D. Murphy, dean of the University of Kansas Medical Center, that state has embarked on a three-point campaign: First, the provision of clinics and hospitals in rural communities; second, expansion of medical training facilities in the state; and third, the development of intensive training and refresher courses for the rural physician. This plan and similar ones in other states have been meeting with great success. In Kansas, rural communities have launched fund drives for the building of clinics and hospitals. With the prospect of up-to-date working facilities at hand, young physicians are being encouraged to take up practice in previously "doctorless" areas. The medical center is being expanded with grants approved by the state legislature. Traveling lecture teams are keeping the country doctor up-to-date on medical and surgical topics. The citizens of the community derive the benefits of this type of modern medical care.

There is a psychological factor in the building of a small local hospital that must not be overlooked. Sick people want to be near their own homes, their families and friends. When hospitalization becomes necessary and local facilities are lacking, the sick person has no choice but to seek hospital care in another community where the needed service is available. As has been pointed out before, this other community may be 30, 40 or 50 miles distant—often too far for frequent visits from friends and relatives. Experience has shown that loneliness and worry over families can delay recovery for many patients.

SMALL HOSPITAL PROBLEMS

Small local hospitals, while filling definite needs in many com-

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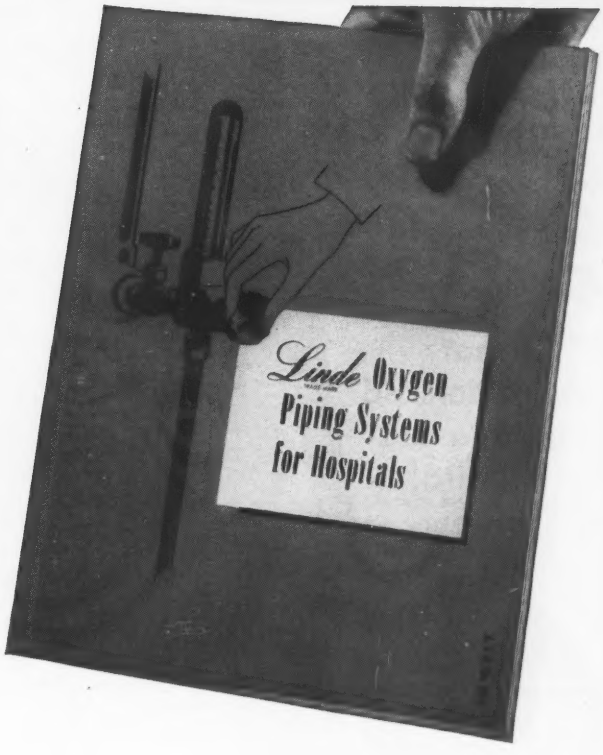

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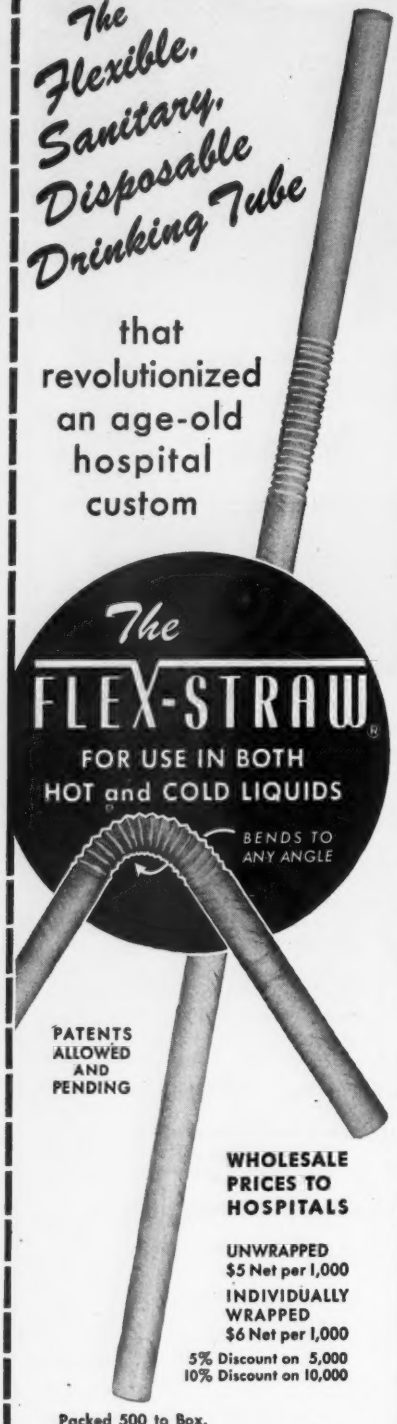

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munities, are nevertheless faced with serious problems.

The small hospital obviously cannot afford to provide many of the services needed by the people in the community. Consequently, it loses many patients to the larger city hospitals where more complete services are available. The result has been that the average small general hospital can count on being used to a lesser percentage of its capacity than the larger hospital.

Low occupancy rates in small hospitals also can be traced to the economic resources of the community. In general, small communities have a greater concentration of low than of high income families. Experience has shown a definite relationship between the demand for hospital care and the ability to pay for it—the lower the financial resources of a community, the lower the use of hospital beds.

Because of the relatively low income in small towns and rural communities, charges for hospital care must be kept comparatively low. As a result, the small hospital in the small community has found it difficult to hold aside sufficient funds for the purchase and maintenance of modern equipment or for the employment of specialized personnel.

This leads us to an additional problem—the temptation given to the small hospital staff to perform services beyond their skills. The less common surgical problems may be undertaken by the local physician who lacks the special skill required. X-ray and other specialized apparatus may be used by physicians or other hospital personnel who are inadequately trained in their use. The results, too frequently, may bring harm to the patient.

These are a few of the problems which the small hospital faces. We know that there is a real need for the small facility in many small communities and rural areas, but we also know that indiscriminate building of small hospitals in all rural areas is not wise.

COORDINATION AS AN ANSWER

Under the Hill-Burton program, our goal is the provision of better hospital care for all people. One step toward this goal is the construction of the necessary physical facilities. This we are now doing. But of greater importance is assuring that these facilities provide efficient and effective service. This can best be accomplished, we believe, by bringing about greater coordination and cooperation among hospitals. Relationships can be developed whereby the larger and more completely equipped and staffed facilities can provide smaller hospitals with the needed services.

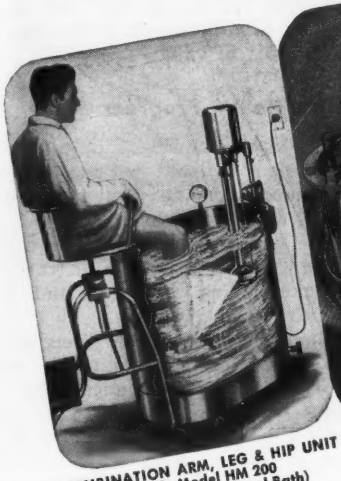
In the future, the "smallness" of a hospital will no longer be determined by its size, but rather in terms of the service which it makes available to its patients. Under a system which coordinates and in-

What regional coordination means

THE CONCEPT OF regional coordination, as envisioned by the Division of Hospital Facilities of the Public Health Service, includes the following functions:

1. The exchange of knowledge related to modern hospital practices and services.
2. Provision of intern or resident services on a part-time basis to hospitals which otherwise would not have them.
3. Provision of consultation and part-time specialist services, including radiology and pathology, to small institutions.
4. Clinical conferences in small community hospitals.
5. Continuation courses for all classes of hospital personnel.
6. Postgraduate training for physicians from small communities.
7. Stimulation and exchange of information on improved hospital administrative methods.
8. Joint planning of hospital and public health programs.
9. The formation of regional hospital councils.

HYDROTHERAPY



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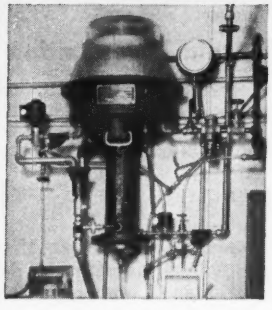

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tegrates the services of its affiliated hospitals, the services that the 50-bed facility can provide are as broad as those of the largest medical center.

Veteran Disabilities

General medical and surgical conditions have disabled almost three-fourths of all veterans on Veterans Administration compensation disability rolls. In a current analysis of the 2,000,000 disabled veterans on its rolls, the Veterans Administration found that 73 per cent suffered medical and surgical disabilities.

Neuropsychiatric conditions cause another 23 per cent of the disabilities, and 4 per cent have tuberculosis.

Of the group with medical conditions, the Veterans Administration study disclosed, 42 per cent involved disabled joints, muscles and tendons.

Comparing the degree of disability of World War II and World War I veterans and the regular establishment, the analysis showed that six out of every 10 World War II veterans had disabilities rated at 20 per cent or less. Among World War I veterans, the rate was five out of 10, and for the regular establishment, it was four out of 10.

Public Health Program

Two new undergraduate programs in public health are being introduced at the University of Michigan, Ann Arbor.

The new programs will provide training in health administration for nonmedical students and in sanitary science.

During the first five years that the new courses are offered, the program will be financed by a grant of not more than $200,000 from the W. K. Kellogg Foundation of Battle Creek, Mich.

Rename Medical Library

In recognition of distinguished service to medicine and the navy, the medical library of the Naval Medical School, National Naval Medical Center, Bethesda, Md., has been renamed as the Edward Rhodes Stitt Library. Redesignation of the library in honor of the late Rear Adm. Edward R. Stitt, M.C., U.S.N., was directed by the surgeon general of the navy, Rear Adm. Clifford A. Swanson.

Admiral Stitt was a pioneer and leader in the field of tropical medicine. From 1920 to 1928 he served as surgeon general of the navy.

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California Unionization

(Continued from page 26)

to the action of February 6. The demand for a contract was ignored. At Redlands, the union had been put to little expense and there was no picket line."

The facts are, of course, that 100 per cent of the nurses who figured in the Redlands incident were and are members of the California State Nurses' Association which has no connection, direct or indirect, officially or ideologically, with the Building Service Employees.

The disturbing feature of this attempt to connect the union with the nurses'. action is that Mr. Gorby should well know these facts or he could have ascertained them by a telephone call.—SHIRLEY C. TITUS, executive director, *California State Nurses' Association, San Francisco.*